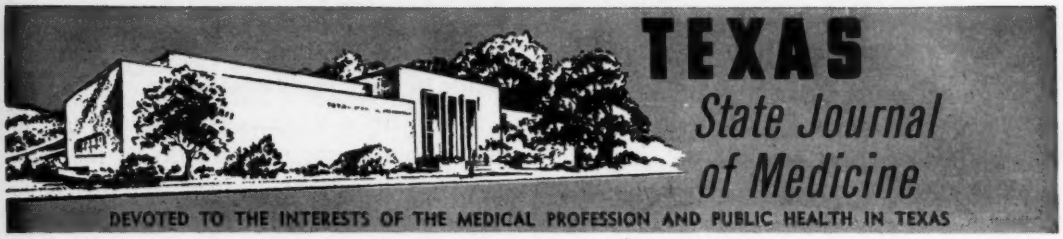

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Occupational Health

By simply caring for patients who are employees, most physicians are concerned, directly or indirectly, with occupational health. Since the majority of employees in this country work in small plants which do not have medical supervision, practicing physicians, especially in industrial areas, should take interest in specific occupational health problems of these patients. This means that the physician should acquaint himself with the working environment and manufacturing processes of these plants. He should be prepared to conduct examinations such as preplacement, periodic, return-to-work, hazardous employment, and preretirement. Most important, he should know enough about plant conditions to give necessary health counseling and guidance to maintain the health of employees.

This is indeed a large order, and most practicing physicians justifiably might resist adding so much to their already heavy burden. However, they will find that improved patient relationship and more accurate diagnosis are particularly worthwhile and rewarding. In fact, to diagnose accurately many occupational diseases the physician must have at least a general knowledge of environmental hazards involved.

I do not propose that all physicians undertake industrial practice. I only wish to make physicians aware of the health aspects of occupational environment. The AMA House of Delegates at its June, 1960, meeting adopted the revised "Scope, Objectives and Functions of Occupational Health Programs," first outlined in June, 1957. The statement contains no fundamental alterations in AMA policy, but it adds new material, including:

1. Greater emphasis on preventive medical and health maintenance concepts of occupational health programs.

2. A more positive statement of organized medicine's obligation to provide leadership in improvement and extension of occupational health services, for example, encouraging the participation of physicians part-time in serving small plants.

Much reference material and many agencies are available to assist the physician. The physician interested in serving employee patients more adequately is urged to familiarize himself with the industrial environment involved and to write his medical society's committee on industrial health and the Council on Occupational Health of the American Medical Association.

—V. C. BAIRD, M.D., Houston.

Insurance for Athletic Injuries

A primary need today is an adequate insurance program which will provide hospitalization for injured athletes, regardless of extent or seriousness of such injuries. Football is a contact sport, and it is inevitable that there will be many injuries occurring in this sport. These injuries vary from minor contusions to severe cerebral and orthopedic disabilities. The principal purpose of athletic insurance is to take care of these injuries on a financial basis which is fair and equitable to both the school and the patient.

At present, the expense of insurance coverage of individual athletes and team has been kept minimal because of existing policies and agreements with the participating insurance carriers. In instances, it has become necessary for expenses to be shared collectively by the persons and school concerned. When injury is severe and hospitalization prolonged, adjustment in expenses are made if insurance coverage is not adequate. Insurance coverage is inadequate and costly to cover long hospitalization periods. At present, financial and medical assistance is obtained frequently without reimbursement to physician or hospital to assist the family of the injured athlete.

Sports are a community program and as such should be the responsibility of the community. Negotiations are now in progress to obtain adequate, reasonable insurance coverage for high school and collegiate athletes to alleviate financial and medical crises which may arise.

—R. G. MCCORKLE, M.D., Austin,
Texas Society of Athletic Team Physicians.

Nueces Society Scholarship

The scholarship being offered for the first time this fall by the Nueces County Medical Society will be one of five county medical society projects presented at the September, 1960, Public Relations Conference of the Texas Medical Association. The grant, reputedly the second of its kind to be offered by a county medical society, is a splendid example of what a local medical society can accomplish by concerted action.

The winner of the scholarship, a resident of the Corpus Christi area, will receive $1,000 a year as long as he continues to merit it for a total of 4 years of advanced training. Eventually, the county society plans to sponsor four students simultaneously, with one scholarship recipient in each class.

Fund raising campaigns such as the one for the American Medical Education Foundation are worthy of support, and much good is accomplished by unified programs of this type. Nevertheless, the example of the Nueces County Society is laudable, since it represents an example of collective effort within a limited area. Such a project enhances the standing of the medical society and county, thus providing an effective means of public relations.

Other county medical societies with adequate financial resources might well consider the establishment of similar scholarship funds.

Governor's Conference on Aging

The problem of aging is not new. Today, members of the medical profession are finding it necessary to assume new responsibilities with regard to care of the aged. Improved techniques, new drugs, advances in medical education are among the factors that have helped to increase longevity. Diligent planning is required to provide medical care for the larger portion of aged persons in the population. Health is the physician's great domain. Ours is the healthiest nation in the world, at least physically. Yet, there has been a tremendous increase in the number of patients with neuroses, functional reactions, and psychoses. These are probably the conditions seen most frequently in the aged. Physicians have controlled fetal death and early mortality from infectious conditions so rampant two decades ago, and thus the rate of the aged population has increased rapidly. What is more alarming, however, is the high rate of mental deterioration and emotional disorders among the elderly.

Problems relative to the needs of the elderly and disabled for skilled care and restorative services require diligent medical planning and attention. The physician must assume the role of leader. Only thus can the ancillary services of the community be coordinated to provide optimal resources for preventive health, rehabilitation, care of long term illnesses, and a healthy emotional climate for senior citizens.

In this regard, Governor Price Daniel has set a Governor's Conference on Aging, to meet September 7-8, 1960, in Austin under the direction of Senator Crawford Martin of Hillsboro. Its purpose is to survey current resources and unmet needs of Texas' aging population in preparation for the first White House Conference on Aging in Washington, D. C., in January, 1961. Recommendations for the White House Conference will be prepared as a result of the Governor's Conference, and will be divided into three sections—local, state, and federal. On November 1, 88 delegates will be appointed to represent Texas at the Washington Conference.

During the state Conference, various committees on aging appointed by the Governor will report. These include an advisory committee of 100 citizens representing every section of the state, 15 members of the Interim-Legislative Committee on Aging, and a nine member steering committee.

As a result of the Interim-Legislative Committee's recommendation, each county judge was asked last March to appoint a chairman or to serve as chairman of a county committee on Aging; 226 such committees were formed. These groups conducted local surveys which have been compiled into the Governor's Committee's "fact finding report" to be presented at the conference.

The Governor's Conference will consist of general sessions and discussion groups of the following six subjects; population trends, income and employment, welfare, health, education and recreation, and housing. Approximately 700 persons are expected to attend.

Obviously, there has been some overlapping of material in the Governor's Conference. The tabulation, sifting, and evaluation of all of this information is necessary to cover all aspects in the study. Texas citizens are being given every chance to represent themselves and their various disciplines in this broad evaluation, and the Texas Medical Association has cooperated fully.

It is hoped that members of the medical profession in Texas will continue to participate, whenever needed, by acting as leaders when problems of the aging and the disabled are discussed. Without such help and guidance, decisions on all levels will be made by groups that lack the medical background necessary to insure safe service-directed policies.

—ELIZABETH C. THOMASON, M.D.,
Committee on Aging,
Texas Medical Association;
ERNEST W. KIEL, M.D., President,
Texas Society on Aging.

President's Page

A Tribute to the Woman's Auxiliary

DR. OWEN

Some members of the Texas Medical Association may have only a slight idea of the many valuable hours members of the Woman's Auxiliary give to a variety of projects that mean much to the Association and allied medical programs. The Auxiliary's project on nurse recruitment, for instance, deserves special comment. The Auxiliary sponsors 370 Future Nurses Clubs with more than 5,000 members. Recently one constituent Auxiliary reported that approximately 50 per cent of the girls in nurses' training in the county were former members of these clubs.

Laudable, also are the Auxiliary's untiring efforts for the American Medical Education Foundation Fund. The Texas organization was second among state auxiliaries in contributions, giving $17,604.81. The Auxiliary's Christmas card this year pictures the Texas Medical Association Building; profit derived from its sales will go to the A.M.E.F. Fund.

Auxiliary members have interests in civil defense, disaster relief, and traffic safety. They are active in community services and in promotion of good public relations for the medical profession. Each Auxiliary has a program for older adults. In addition, members sponsor projects to help the aged help themselves, and they have initiated a study of voluntary health insurance plans. For many years the Auxiliary has provided aid for needy doctors' widows and children through a memorial fund. On many occasions funds from this source have meant a great deal; in one instance a widow's home was thus saved. It is regrettable that this excellent program does not have a counterpart in county medical societies. Several state societies, however, have similar programs for physicians.

Members of the Woman's Auxiliary are active participants in the projects of their separate communities. This is as it should be. We owe our best efforts to improvement of the many fine programs that make up community life—which, in turn, better our state and nation. For their contributions to their respective communities and to the Texas Medical Association, we say gratefully, "Thank you."

May Owen

Pro / Con

A column for readers' assents, dissents, and comments, selected monthly by the official advisory committee of the Texas State Journal of Medicine.

Physician Holds Key In Controlling VA Medical Program

The Veterans Administration operates the largest system of hospitals in the world. This system practices medicine, paid for with tax funds from Congressional appropriations. The patients belong to the government with no choice whatever in regard to physician, facility, or treatment. This ("a rose by any other name . . .") is socialized medicine.

Some of us say we are doing everything within our power to oppose federal encroachment on the private practice of medicine, but are we? Could a physician be passionately devoted to preservation of the free practice of medicine and still make regular consultation trips to a Veterans Administration hospital? Could a similarly motivated medical school professor or dean abet the VA hospital program by his personal or his school's participation? *Could the physician in private practice aid the program by referring patients?* Is it really a threat to private practice?

The Committee on Military and Veterans Affairs of the Texas Medical Association has for 3 years conducted an exhaustive study of the VA medical program. The committee's source material has included data from the Council on Legislative Activities of the American Medical Association, official publications of the United States Government, transcripts of hearings of Congressional committees, and data from the three Texas medical schools.

Scope of VA Program.—The Veterans Administration operates 173 hospitals in the United States and Puerto Rico. Bed capacity is approximately 120,000, and average daily in-patient census approximately 111,000. There are 3,000 VA patients in contract beds in hospitals not operated by the governmental agency.

The Department of Medicine and Surgery of the Veterans Administration employs approximately 4,600 physicians, 792 dentists, 15,000 registered nurses, and untold numbers of laboratory and x-ray technicians, therapists, and dietitians. Other employees include all classifications of ancillary professional, technical, and yeoman personnel.

Service Connection.—Regularly 66 per cent of in-patients and 85 per cent of patients discharged are treated for conditions in no way related to service-connected disability. The actual figure is really a little higher, because many with a service-connected disability are treated primarily for other conditions while in the hospital.

Source of Patients.—Dr. Middleton, medical director of the Veterans Administration, stated that previous surveys showed between 15 and 30 per cent of VA admissions were referred by private doctors. Our investigations have shown this figure to be considerably higher; one documented study showed that 63 per cent of 228 admissions in a specific period were referred by private doctors or from private or city-county hospitals.

Letters are chosen on any subject on the basis of good taste, propriety, and available space by the Journal Advisory Committee. No anonymous letters will be printed and the committee reserves the rights to print and to edit contributions. Letters do not necessarily represent the policy of the Texas Medical Association or the Journal.

VA Hospital and Medical Schools.—Baylor University College of Medicine in Houston and the University of Texas Southwestern Medical School in Dallas both have extensive associations with the VA Dean's Committee hospitals in their areas. For example, Baylor's faculty controls 163 approved residency positions in non-VA hospitals in the Houston area, and there are 91 approved residency positions

under the same auspices in the VA hospitals (which have no obstetrics, or pediatrics). Southwestern has 129 approved residency positions at its non-VA teaching hospital and 57 in the VA. Faculty members of both schools participate extensively in the VA teaching program, and a sizable portion of faculty personal income comes from VA sources. For example, 118 members of the Baylor faculty receive $156,810 annually from the VA in salary or consultation fees.

Medical Classification.—Repeatedly, VA officials have stated publicly that nonservice-connected patients with acute medical and surgical problems, who require elective surgery, are essential for maintenance of their residency program. The VA hospitals admit exactly the same types of patients that are necessary for the conduct of adequate residency training programs in hospitals not operated by the federal government. Approximately 30 per cent of approved specialty residencies in this country are in government hospitals. Actual utilization may be higher because of higher salaries and university hospital affiliations in VA and other governmental hospitals.

Conclusions.—When the facts are analyzed, VA hospitals are not primarily serving the service-connected veteran for which they were originally intended, but rather are operating a full medical and surgical program for nonservice-connected diseases. In actuality, they compete against private hospitals, against local and regional postgradaute training programs, against private doctors, and—most important of all—against the patient not in a VA hospital for adequate hospital care. The competition against patients is effected by the hiring of thousands of house officers, registered nurses, laboratory and x-ray technicians, dietitians, and other ancillary personnel, all of whom are in short supply. The higher VA pay scales add to the difficulty, using the public's tax money, and have contributed to an increase in costs of hospital care.

WHAT CAN WE DO?

At first glance, it would seem appropriate that the physician write Congressman and state that he is against admission of patients to federal hospitals for treatment of nonservice-connected disabilities. This has been done repeatedly, and in all instances, ineffectively. The truth is that *it is the will of Congress* that nonservice-connected patients shall be cared for if they are needy. The first time that the Congress so voted was in 1934, and the bill was passed over a Presidential veto. What about a big publicity campaign to call attention to the freeloaders who go to the VA hospitals when they can afford private care or do not really need to be in a hospital? This too has been tried on a limited scale and has failed. That is probably just as well, because such an approach almost always has an adverse public relations effect on the medical profession. The record proves that all other methods have failed too.

The Association's Committee on Military and Veterans Affairs has looked hard for a solution. There seems to be only one ultimate answer. The only way that operations of the VA hospital system will be curtailed is to decrease Congressional appropriations. The only way that Congressional appropriations will be decreased is by a marked and sustained decrease in the in-patient census of VA hospitals, and the only way that physicians can decrease the in-patient census is to *stop sending patients to VA hospitals.* This means physicians in their private offices, in private hospitals and clinics, in city-county and other public hospitals, in clinics and emergency rooms, and everywhere. There really is no other solution.

The only ones who can accomplish this task are the physicians and hospitals of Texas. Alternate routes for referral of needy patients are available. We *must* use them.

—MILTON V. DAVIS, M.D. Chairman,
Committee on Military and Veterans Affairs,
Texas Medical Association.

Sunburn, pigmentation, aging, and carcinogenesis are discussed in detail. The public should be educated in regard to the harmful effects of chronic exposure to sunlight. Commercially available sunscreens, such as benzophenones and para-aminobenzoic acid, can provide excellent protection.

HARMFUL EFFECTS OF SUNLIGHT

Physical and Chemical Sunscreens

JOHN M. KNOX, M.D.
Houston, Texas

IN OPPOSITION to the highly publicized and currently popular suntan fad, dermatologists in the Southwest have become increasingly conscious of the harmful effects of sunlight.

The present trend in our sociologic and economic pattern is toward more time and money for recreation, and much of this time will be spent outdoors. In the past, only farmers, sailors, and other outdoor workers were exposed to significant amounts of irradiation from sunlight. Today, and in the future, with more people spending additional time under the sun, plus the fact that life expectancy is continually being prolonged, there is definite need for knowledge in regard to the undesirable effects of sunlight and possible means for their prevention.

The term "sunlight" includes, in addition to visible light, both ultraviolet and infrared light. Ultraviolet wave lengths are shorter than visible wave lengths; whereas, infrared rays are longer than those of visible light. Most of the harmful effects of sunlight are caused by ultraviolet rays, for they produce sunburn, pigmentary changes, degeneration of the skin, and the common forms of skin cancer. Photoallergic, phototoxic, and photodynamic reactions may be produced by longer wave lengths in addition to ultraviolet rays. Since most adverse effects from sunlight are caused by ultraviolet rays, this discussion will be limited almost entirely to ultraviolet wave lengths.

Ultraviolet rays are electromagnetic waves and, therefore, have many features in common with roentgen rays and other forms of irradiation. An ultraviolet wave is longer than a roentgen-ray wave, and ultraviolet photons carry less energy than roentgen-ray photons. Although not classified as a form

of ionizing irradiation, ultraviolet can produce some ionization.[1] Photons of ultraviolet energy are absorbed by the skin, and there is no penetration beyond a few millimeters.[3] The stratum corneum both absorbs and scatters these rays. Therefore, this outermost layer of the skin provides considerable protection from sunlight. The degree of protection is determined by two factors—the thickness of the stratum corneum and the quantity of melanin it contains. Thomson[14] has shown that the number of melanin granules in the stratum corneum significantly influences its ability to absorb ultraviolet light. Melanin in the malpighian and basal cell layers provides additional protection for the skin.

Sunburn and Suntan

Sunburn is produced by a well defined portion of the electromagnetic spectrum which is located between 2900 and 3170 angstrom units, with the maximal effect at 2970 angstroms.[3] Protein absorbs light within the sunburn spectrum, and rays which penetrate the stratum corneum are absorbed by proteins, including nucleoproteins of the less superficial epidermal cells. The absorption of this energy produces biochemical changes which result in erythema, actinic degeneration, and carcinogenesis. The mechanism through which ultraviolet produces erythema is not established. However, it is theorized that injured cells liberate leukotaxine and other substances which induce inflammation.

Whether an individual sunburns is dependent on many variables—duration and intensity of exposure, season, latitude, altitude, smoke, clouds, and degree of natural protection afforded by the epidermis. There are more erythemogenic wave lengths present in sunlight of southern than northern latitudes, around midday than early or late in the day, at high altitudes because of less atmospheric absorption, and on the seashore where reflectance increases the intensity of an exposure. Smoke, clouds, suntan, shade, and clothing provide protection.

Sunburn may be produced by natural sunlight or by artificial sources of ultraviolet irradiation, such as a hot or cold quartz lamp. The atmosphere, particularly ozone, filters the shorter wave lengths of sunlight, and only wave lengths of 2900 and above reach the earth.[6] The erythema-producing waves of sunlight are from 2900 to 3170 angstroms in length, and a hot quartz lamp produces these wave lengths. Cold quartz erythema is caused by wave lengths of 2537 angstroms. Therefore, the erythema produced by a cold quartz ultraviolet lamp is caused by wave lengths shorter than those in natural sunlight.

Susceptibility to sunburn is inversely proportional to the amount of pigment in the epidermis. A vivid example is the difference in tolerance to sunlight between an albino Negro and a dark-skinned Negro —the albino is highly susceptible to sunburn and the dark Negro has remarkable tolerance to sunlight. Most individuals can obtain a suntan and, thereby, increase their tolerance to sunlight. Suntanning involves three different processes—oxidation of melanin, dispersion of melanin, and production of new melanin. Reduced melanin is tan, and oxidized melanin is brown to black.

Ultraviolet wave lengths between 3000 and 4200 angstroms, with the peak being approximately 3400 angstroms, have the ability to oxidize melanin. Oxidation occurs within a few hours after irradiation. Ultraviolet also has the ability to cause dispersion of melanin granules within the melanocytes, and skin in which the melanin is dispersed is darker than it was before dispersion. This dispersion reaction occurs at 3400 angstroms and does not reach its maximum for several days after irradiation. New melanin production is initiated by wave lengths from 2800 to 3100 angstroms. New melanin is first noticed after 48 hours and melanin production reaches its peak in approximately 19 days.[11] Freckling is a type of tanning which occurs most commonly in persons with red and reddish-brown hair. In a freckle, the number of melanocytes is normal or actually decreased. However, there is an unusually large amount of pigment in the melanocytes of a freckle.[2]

Dr. John M. Knox of Houston is associate professor of dermatology at Baylor University College of Medicine, Houston.

Sunscreens can provide excellent protection from sunburn. Rothman[12] has shown that 15 per cent para-aminobenzoic acid cream can increase the amount of irradiation required to produce erythema by 50 to 100 times. The families of compounds most frequently employed in sunscreens are para-aminobenzoates, anthranilates, cinnamates, pyrrones, benzimidazoles, carbazoles, naphtholsulfonates, and quinine disulfate.[4] The first commercial sunscreen appeared in 1928 and contained benzyl salicylate and benzyl cinnamate as the active ingredients. Recently, Knox and others[9] studied a new group of sunscreening agents, the benzophenones, and found them to be equal or superior to other agents tested. Benzophenones have a wide absorption spectrum which

includes not only the erythematous wave lengths, but also those causing pigmentation and many of the more common photosensitivity phenomena. During this study, the popularly employed suntan lotions and creams increased the minimal erythema threshold 4 to 6 times. Therefore, a sunbather protected by one of these formulations could remain in the sun 4 to 6 times as long before obtaining a burn. Ten per cent concentrations of 3-benzoyl-4-hydroxy-6-methoxy-benzenesulfonic acid and para-aminobenzoic acid in vanishing cream increased the minimal erythema dose approximately 100 times.

Since benzophenones absorb the wave lengths responsible for pigmentation, derivatives of para-aminobenzoic acid are probably the best currently available sunscreens for individuals desiring a suntan. For those who need protection from sunlight and are not desirous of obtaining a tan, a benzophenone sunscreen would be the preparation of choice. Stegmaier tested a benzophenone and found that it was superior to an equal concentration of para-aminobenzoic acid for inhibiting 8-methoxypsoralen accelerated pigmentation.[7] A sunscreen of the benzophenone type might be useful for individuals who freckle, patients with chloasma, and those who prefer their natural color to a tan. Window glass prevents sunburn by filtering the erythemogenic wave lengths. Physical sunscreens (sunshades) are opaque chemicals that scatter light rather than absorb it. Titanium dioxide, talc, kaolin, zinc oxide, and bentonite are examples. Occasionally these chemicals are used in combination with the previously described chemical sunscreens. A cream vehicle alone provides some protection, and petrolatum, particularly red petrolatum, provides considerable protection.

Aging and Epitheliomas

During a lifetime, the skin is exposed to a large amount of irradiation from sunlight. This, of course, varies with occupation, recreational habits, geographical factors, and clothing. Unna[15] was first to call attention to the high incidence of skin cancer among sailors exposed to sunlight, and his findings and conclusions have been confirmed by others. Although carcinogenesis has been emphasized adequately, there has been relatively little comment in the literature in regard to the role sunlight plays in aging of the skin. Many visible signs of aging are the results of accumulated ultraviolet damage. Such findings are evident both grossly and histologically. Among the changes related to exposure to sunlight are a dry, coarse, and leathery appearance of the skin; laxity with wrinkling; and various pigmentary changes. With its natural protection, the Negro skin has much less actinic damage, and elderly Negroes often manifest a deceptively youthful appearance.

If one examines an elderly person's skin, there is a striking difference between the light-exposed regions and those protected by clothing. The chest, for example, of a 70 year old woman often appears young and relatively normal in contrast to her weathered, wrinkled, and aged face. Although there are obvious anatomic differences in the skin of the chest and the face, the clinical and histologic evidences of aging induced by sunlight are striking. A weather-beaten farmer often appears considerably older than a similarly aged physician. These differences would be even more apparent were it not for graying, skeletal changes, and other phenomena that accompany aging.

In addition to the cosmetic ill effects of chronic exposure to sunlight, skin which has been damaged by sunlight is predisposed to development of premalignant and malignant skin tumors. Fair-skinned individuals who have been exposed to large amounts of sunshine have the highest incidence of skin cancer. Recently, Mcdonald[10] compiled some interesting statistics on this subject. The carcinogenic wave lengths of the spectrum are between 2900 and 3341 Å. In experimental animals, the amount of radiant energy necessary to precipitate carcinogenesis is relatively small, being in the neighborhood of 63 to 84 by 10^7 ergs/cm.[2 13] In animals the length of the precancerous period varies inversely with the daily dose of irradiation, and carcinogenesis, once initiated, proceeds without further exposure to radiant energy. Although animal studies cannot always be transferred to man, a similar situation appears to exist.

Members of this department began a series of experiments to investigate possible means of inhibiting experimentally induced ultraviolet carcinogenesis. Swiss strain albino mice were irradiated daily, 5 days a week, with various sources of ultraviolet light. Since 8-methoxypsoralen may be used to accelerate carcinogenesis,[5] selected groups of animals were given the drug for this purpose. These experiments showed that topical sunscreens, such as 3-benzyl-4-hydroxy-6-methoxy-benzophenones and para-aminobenzoic acid, were extremely effective in preventing ultraviolet induced carcinogenesis.[7] Possibly of even more significance, additional studies revealed that the systemic administration of antimalarials or benzophenone decreased carcinogenesis.[8] Control animals had approximately twice as many tumors as those receiving these drugs.

Comment

The currently available clinical, pathologic, and experimental evidence indicates that physicians, parents, and responsible members of our society should begin an educational campaign on the harmful effects of sunlight, including aging and carcinogenesis. The

public also should be informed on appropriate means of protection. Excellent sunscreens are commercially available, and there is no reason why these agents should not be used when needed. Currently, they are employed almost exclusively to prevent sunburn or for photosensitivity. Their potential usefulness in prophylaxis against aging and carcinogenesis has not been exploited. It is probably premature to recommend the antimalarials or other systemic agents for such purposes since there are hazards to the prolonged use of any systemic medication. Possibly, however, an effective systemic prophylactic agent may be established in the not too distant future.

Since effective means of preventing damage by acute or chronic exposure to sunlight are available, physicians should take the lead in educating the public on this subject. A major part of this educational program should be to emphasize the adverse effects of sunlight, for today there is far more interest in the good than the harm resulting from sunlight. For years it has been popular to obtain a suntan, and for many people, particularly medium to fair-skinned individuals, the exposures necessary to produce a tan probably injure the skin. One who obtains a tan rapidly and easily is, in all probability, already dark-skinned, and from a cosmetic standpoint, there is no real need for the skin to be darker. The medium to fair-skinned person who wants a tan probably should not subject himself to the exposures necessary to accomplish this purpose. The suntan lotion, although of value, is not a perfect agent in the sense that it will selectively allow tanning but exclude all adverse effects of irradiation.

A blonde woman usually shows her age more than a brunette, and this is to a large extent the result of sunlight induced degenerative changes. Aging is a prime concern to every woman; therefore, sunscreens might be incorporated in face powder, make-up bases, and other commonly used cosmetic preparations. Although a case of epidermal contact sensitivity might occur occasionally, these agents are relatively innocuous. If blondes were informed adequately on this subject, they could protect their skin and probably retain a youthful appearance for a considerably longer period. Actually, fair-skinned individuals should never be engulfed into the suntan fad. They should use sunscreens routinely and limit exposures to worthwhile occasions. This does not imply in any way that outdoor activities for blondes are taboo; it only means that the ill effects of sunshine should be recognized and understood so that harmful exposures can be avoided.

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A series of animal experiments have indicated that topical application of a benzophenone, BSA, or para-aminobenzoic acid decreases the carcinogenic effect of ultraviolet light in albino mice. Oral administration of antimalarial drugs and BSA seemed to inhibit carcinogenesis partially. Present findings in a small number of animals appear significant enough to warrant further investigation.

Experimental Ultraviolet Carcinogenesis

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CANCER OF THE SKIN is more common than any other form of cancer in Texas. In El Paso, where excellent records have been kept, approximately 30 per cent of cancers reported are epidermal in origin.[13] Studies of cutaneous malignant tumors have contributed much to present understanding of carcinogenesis. The carcinogenic potentiality of chemicals such as hydrocarbons became apparent many years ago when "chimney sweeps" were observed to have scrotal cancer. Sunlight and other forms of irradiation such as roentgen rays have long been known to be capable of causing cellular alterations that result in cancer. Unna[18] first noted that skin cancer was common in sailors and individuals exposed to sunlight for prolonged periods. Epitheliomas can be produced experimentally by exposure of albino mice, rats, and rabbits to the ultraviolet rays of a mercury arc lamp.[2] Although much has been learned, the study of cutaneous malignant growths should continue to be a fertile field for research.

A variety of agents have been used to produce skin cancer experimentally. Orr[14] recently mentioned that many, but not all, polycyclic hydrocarbons are carcinogenic. He emphasizes that skin cancer can be caused by various kinds of radiation, for example, ultraviolet light and roentgen rays, but that formation of epithelial tumors by radiation takes 3 to 4 times as long as that by chemical carcinogens. Zackheim[20] discovered that many kinds of tumors occurred in rats after application of 2-anthramine for periods varying from 6 to 14 months. Basal cell epitheliomas were the most common, but prickle cell papilloma, prickle cell carcinoma, sebaceous adenoma, sebaceous epithelioma, cylindroma, and fibrosarcoma were also induced. In mice treated the same way, no basal cell epithelioma developed. Recently Winkelmann and colleagues[19] produced numerous squamous cell carcinomas when they exposed hairless mice to ultraviolet light. It was not necessary to burn or damage the skin in these animals to induce this change.

To exert a biologic effect on tissues, radiant energy must be absorbed because, according to Draper's Law (1870), only the energy absorbed by a system can exert any influence upon it. Reflected or trans-

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TABLE 1.—*Effect of Topical Application of BSA in Mice Treated with 8-MP* Before Ultraviolet Irradiation.*

No. of Animals	Treatment	Appearance of Ears (Damage)		Tumor Incidence	
Started/Survived	8-MP	Right Ears (BSA)	Left Ears (Alcohol)	Right Ears (BSA)	Left Ears (Alcohol)
20/14	Controls	Normal	Severe (100%)	None	28%
20/20	8-MP in Diet	Normal	Normal (15%) Slight (25%) Moderate (30%) Severe (30%)	None	15%
20/13	8-MP Injected	Normal	Severe	None	46%

Irradiated 20 min./day with mercury arc lamp at a distance of 50 cm.
* 8-Methoxypsoralen.

mitted energy is without effect. The unit of measurement of absorbed radiation is the quantum. The shorter the wave length, the higher the quantum; thus, energy from a quantum of ultraviolet light is greater than from infrared rays, but less than that of roentgen rays. Small doses of ultraviolet light cause alterations in nucleoproteins, and repeated exposures can yield changes significant enough to result in development of skin cancer.[3] The amount of effective mid-ultraviolet radiant energy necessary to initiate changes which culminate in tumor formation is relatively small (6.3 by 8.4 by 10^8 ergs/cm.^{2}).[16]

There is definite need for establishment of means for protection of people who are exposed to sunlight for long periods. Since there are innumerable complications and problems related to investigation of carcinogenesis in human beings, animal studies are useful.

Protection from Ultraviolet Carcinogenesis

Topical protection.—Certain chemicals may be used to eliminate or minimize deleterious effect of the ultraviolet rays of sunlight by absorbing and dissipating this energy in a harmless manner. In search for possible means of protecting humans from sunlight, our group began a series of studies. The first step was to review the families of compounds used as sunscreens, and to introduce a new group of promising chemical sunscreens, the substituted benzophenones.[10] This class of absorbers is different from most organic compounds in that it has an exceptionally wide absorption spectrum and is resistant to photochemical degradation. Benzophenones are currently used in textiles, dyes, paints and plastics to protect them from photochemical degradation. Experimental and clinical findings showed that the benzophenones selected provide excellent protection from erythema-producing ultraviolet wave lengths. These compounds were superior to a large group of commercial sunscreening and suntanning agents, and were equal to or better than comparable percentages of tannic acid and para-aminobenzoic acid.

The benzophenone, 3-benzoyl-4-hydroxy-6-methoxy-benzenesulfonic acid, because of its stability and free solubility in water and alcohol, was chosen to see if such a sunscreen would provide protection from the carcinogenic effect of ultraviolet light. For convenience, this compound will be referred to henceforth under the abbreviation "BSA." A series of investigations[8] demonstrated that topical application of BSA or para-aminobenzoic acid can decrease greatly both the erythematous and carcinogenic re-

TABLE 2.—*Effect of BSA After 8-MP Injection and Exposure to Longer Ultraviolet Wave Lengths.*

No. of Animals	Treatment		
Started/Survived	All Mice Injected with 0.4 mg. 8-MP	Degree of Damage in Mice	Percentage of Tumors
20/14	Controls	All ears severely damaged. Most eyes damaged—many with cataracts.	Definite (29%) Questionable (21%)
20/20	5% BSA in Diet	No Damage (15%) Slight Damage (65%) Moderate Damage (20%)	None

Longer wave length ultraviolet irradiation (3,200-4,000 Å).
Irradiated 10 min./day with Blak-Ray lamp at a distance of 45 cm. for 17 weeks.

TABLE 3.—*Effect of Antimalarials upon the Erythematous and Carcinogenic Response to Irradiation with the Mercury Arc Lamp.*

No. of Animals	Treatment	Erythematous Effect	Percentage of Tumor Incidence	
Started/Survived	Diet	Degree of Erythema	At Conclusion of Experiment	After 3 Months Observation
20/11	Controls	Severe	50%	50%
14/4	Triquin	Very Slight	18%	25%
20/5	8-MP	Very Severe	36%	40%
20/8	Triquin and 8-MP	Moderate	9%	12%

Irradiated 10 min./day with mercury arc lamp at a distance of 50 cm. for 6 months.

sponse of albino mice to ultraviolet light irradiation. Other studies in this series indicated that administration of 8-methoxypsoralen will cause severe erythema and a high incidence of tumors in mice when the animals are exposed to usually harmless long wave lengths (Wood's light).[5] A related experiment showed that 8-methoxypsoralen can induce erythema and tumors in mice maintained under fluorescent light.[6] Even when the erythematous and carcinogenic process was accelerated by intraperitoneal administration of 8-methoxypsoralen, BSA and para-aminobenzoic acid were highly effective in prevention of damage and tumors. Psoralen had no appreciable effect upon shorter wave length radiation (the germicidal far ultraviolet).

Oral protection.—The antimalarial drugs are useful in the treatment of patients with discoid lupus erythematosus[15] and solar dermatitis.[11] Since these agents seem to alter tissue responses in some diseases, they appeared to warrant evaluation, along with the benzophenones, as possible oral means of protection. Appreciable amounts of these drugs localize in the skin, even though larger amounts are deposited in the liver and spleen, and, to some extent, in the kidneys and lungs.

The exact mechanism of action of the antimalarial drugs in light sensitive diseases is unknown. A widely considered possibility is that these agents act by screening certain ultraviolet wave lengths from sunlight, thereby diminishing the harmful effect on light sensitive skin. Beal[1] has shown that chloroquine absorbs some of the offending rays involved in solar urticaria. Cahn and co-workers have expressed the view that abnormal, but not normal, skin responses to ultraviolet light are altered. Recently, Shaffer and his associates[17] measured the absorption curves of epidermis and corium taken from abdominal skin of normal volunteers, each of whom had ingested 1 of several antimalarials. Other volunteers acted as controls. The amount of antimalarials in the epidermis was not sufficient to act as a significant physical barrier to the passage of ultraviolet light. Kurnich[12] suggested that these drugs may have an affinity to combine with nucleic acids, preventing the deposition of depolymerized nucleoprotein in tissues to form collagenous lesions. Other suggestions are that they act by adenosine triphosphate inhibition,[7] or even adenosine triphosphate sparing action.[4]

In our experiments,[9] albino mice were fed chloroquine or Triquin,* alone or in combination with 8-methoxypsoralen. One control group was fed the usual chow ration and the other was given 8-methoxypsoralen in the diet. All animals were exposed 10 minutes each day, 6 days a week, at a distance of 50 cm. from a mercury arc lamp. After 6 months, ultraviolet irradiation was discontinued and conditions of the mice were evaluated. After an additional 3 months' observation period, their conditions were reevaluated. Animals that had received antimalarials, especially Triquin, had fewer tumors than the controls. Those that had received the antimalarials in combination with 8-methoxypsoralen in the diet had more tumors, but not as many as the controls. Similar studies showed that oral BSA was also partially effective in protecting mice from the carcinogenic effect of ultraviolet light.

These results in a small number of animals appear significant enough to warrant further investigation.

TABLE 4.—*Effect of Topical Application of BSA with Subsequent Ultraviolet Exposure.*

Swiss Albino Mice	Treatment	Results	
	Topical Application	Percentage Ears Grossly Damaged	Percentage Ear Tumors
Right Ears	10% BSA in Alcohol	No Visible Damage	3%
Left Ears	Alcohol	48%	27%*

Irradiated 15 min./day with mercury arc lamp at a distance of 50 cm. for 5 months.

*Many of the left ears were totally sloughed off, reducing the possibility of larger tumor incidence.

*Triquin—chloroquine diphosphate, quinacrine hydrochloride, and hydroxychloroquine. Winthrop Laboratories, New York, N. Y.

Whether any of these experiments will be applicable to man has yet to be determined. At present, the authors are conducting a double-blind clinical study to determine whether chloroquine will prevent new lesions in patients with actinic degeneration, senile keratoses, and skin cancer.

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Improvement in materials and fitting techniques for contact lenses, and patient demand for them, has made it almost imperative that ophthalmologists equip their offices for such practice.

FITTING CONTACT LENSES: *Practical Points*

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DEVELOPMENT of the contact lens as an aid to the visually handicapped ranks as a triumph of ophthalmic research. For many years, contact lenses were made of glass and were fitted for some types of eye therapy and eye protection and to correct extreme errors of refraction.[1, 8] After 1938, availability of the newer plastics expanded usage. During the early years, it was necessary to make a mold of the front of the eye and to make the lens conform to this mold. Long tedious hours were required to complete a satisfactory fitting, and wearing time was a few hours at the most because of discomfort and haziness resulting from edema of the cornea.[7, 11] The large scleral type lens first used has been almost replaced by the small corneal lens, except for use in certain types of sports, and for protection.[7, 8] Fitting the small fluidless corneal lens, once a trial-and-error process, has been developed into a more exact science as the result of modern instruments and discoveries. Fitting the modern corneal contact lens requires minimal time for initial refraction and necessary measurements. Laboratories are equipped to make quick delivery, usually not more than 5 to 10 days after they receive the prescription, after which the patient requires a short office visit for instruction. Brief follow-up visits may be necessary for accurate checking of the fit and for reassurance during the period of adaptation.

Ophthalmologists cannot ignore contact lenses. They have been developed to the point that they are an important adjunct in the practice of ophthalmology.[4, 12] It is not unusual to find patients wearing the lenses for 8 to 16 hours, with little or no discomfort. Frequently, lay publications, radio, and television relate the great advances made in contact lenses. Regardless of any prejudice ophthalmologists might have, patients wearing glasses with strong corrections do not like the resulting cosmetic defect. If ophthalmologists do not fit them, someone else will.

Types Benefited by Lenses

Many types of conditions such as keratoconus, monocular aphakia, binocular aphakia, myopia, lid disease, irregular astigmatism, and corneal scars are greatly aided by contact lenses. Patients in hazardous occupations may find it advantageous to wear the lenses. Several years ago when the fluidless scleral lens became available, many athletes were fitted who had high degrees of refractive error requiring strong spectacle lenses, a definite hazard in football and basketball. The lenses permitted perfect visual acuity, widened visual field,[10, 12] and eliminated the hazard of external glasses, but the wearing time was limited to 3 to 6 hours.[7, 11]

Monocular and binocular aphakia respond well to the fitting of contact lenses.[2-5, 9] Most cataract spectacle lenses are heavy and thick, and limit the visual field. Several cases in which the author fitted a corneal lens to the aphakic eye after extraction of a cataractous lens with resultant binocular vision has caused earlier operation on patients with monocular cataracts. Many articles in the literature on this subject show the superiority of the contact lens over the telescopic lens as a means of correction.[2-5, 9, 12, 13] An ordinary cataract spectacle lens increases the retinal image in an aphakic eye by about 36 per cent, whereas the retinal image with a contact lens in an aphakic eye is increased about 5.34 per cent.[10] With a contact lens on the aphakic eye, the retinal image is reduced enough to make binocular vision possible in most instances.

Myopia is probably the most common defect corrected by contact lenses. Myopes with high refractive errors derive more benefit from contact lenses than regular ophthalmic lenses because contact lenses increase the size of the retinal image.[12] For example, a myope of 6 diopters magnifies the retinal image approximately 10 per cent; a 20 diopter myope magnifies the retinal image approximately 46 per cent. Contact lenses for such patients give a nearly normal field of vision and eliminate the prismatic effect of strong lenses. They are usually well tolerated because of the great improvement in vision and, likewise, cosmetic result.

Contact lenses are indicated in neuroparalytic keratitis and in various types of lid disease as a prophylactic or protective device.[8] Many patients with types of irregular astigmatism and scarred corneas receive greatly improved vision over that possible with ordinary spectacles. Strong correcting lenses can be a handicap to actors, entertainers, foundry workers, and others whose eyes are exposed to physical damage.[6] Keratoconus is difficult to fit with any type of lens but a contact lens offers the greatest improvement in visual acuity and protection of the abnormal cornea.

Screening Patients

Screening patients is important to eliminate the type of individual whom the ophthalmologist thinks will not be happy with contact lenses. Generally, one should discourage fitting contact lenses for patients whose regular spectacle lenses are of low dioptric value. Such patients do not get benefit enough from contact lenses to justify the patience required to adjust. The aged, especially those in the bifocal group, do not adjust readily to contact lenses; nor do persons with certain diseases. Included are those with ocular allergy, a ptyergium which extends to the cornea, general nervousness, and debilitation, and any inflammatory condition of the globe or adnexa.

The most important single factor in satisfactorily fitting contact lenses is a high degree of motivation by the patient. The author usually (1) explains to the patient what a contact lens will do, (2) tells him what he can expect from these lenses, (3) allows him to purchase the lenses rather than trying to sell him on something which he may decide later he did not want, and (4) instills confidence in him (demonstration with a sample contact lens may help). Regardless of the exactness of the physician's fitting technique, he should continue to carefully select patients for whom he fits contact lenses.

Fitting Lenses

Fitting a contact lens is relatively simple. Time required with the patient makes contact lens fitting as economically feasible as fitting ordinary spectacles. Fitting contact lenses requires the usual equipment for refraction, an accurate instrument such as the keratometer or ophthalmometer for measuring cor-

Dr. Malone, who practices ophthalmology in Big Spring, presented this paper before the Section on Eye, Ear, Nose, and Throat at the annual session of Texas Medical Association on April 12, 1960.

neal curvature. A trial set of contact lenses is desirable, but is not a necessity.

The author does manifest refraction or, if indicated, a cycloplegic refraction. The diameter of the cornea is measured in millimeters to the nearest one-tenth, and the corneal curves with the keratometer. This information is submitted to the laboratory which grinds the prescription contact lens for each eye according to the radius of the cornea, diameter of the cornea, and refractive power. Occasionally, if time permits, the ophthalmologist uses the contact lens trial case to check the fit of the lens with the keratometer reading and to do a refraction.

Most modern corneal contact lenses are fitted parallel to the flattest corneal curve. Accurate measurement of the corneal curvature is essential. The keratometer or ophthalmometer should be checked frequently with an artificial cornea or steel ball on which radius of curvature is accurate and known. Multiple measurements of the cornea are made, and

the average is taken for the final reading. An instrument should be obtained for measuring the diameter to the nearest tenth of a millimeter. The prescription laboratory will need this information although there are lenses on the market which are ground to a standard 9.2 mm. of diameter. The author prefers to know the diameter of the patient's cornea regardless of which type is used. Some laboratories make the diameter of the finished lens correct in accordance with a predetermined chart, using the diameter submitted. Lens thickness is determined at the laboratory, depending upon the power of the lens, unless otherwise specified by the physician. On prescriptions which have a power of plus or minus 5 diopters, vertex distance should be given the laboratory so that proper allowance can be made in the final contact lens prescription. Base and peripheral curves may be ordered as desired, or they will be supplied in accordance with standard procedure from the ophthalmologist's corneal curve measurements. The examiner may make final calculations as to the radius of the lens, peripheral curves, and power of the lens. In most instances, such calculations can be made by the laboratory manufacturing the lens.

Upon receipt of the lenses from the laboratory, the patient is notified and an appointment is arranged. This visit is one of the most important so far as patient satisfaction is concerned. Again, the principle of wearing contact lenses is explained fully. The patient should be told that the lens floats upon tears, does not touch the front of the eyeball, and will not harm the eye. Careful instructions are given for cleaning the lenses (soaking them overnight), wearing time, and technique of insertion and removal. The lenses are carefully cleaned and sterilized with the proper solution in the patient's presence, and are gently inserted with the patient looking down and forward. The patient is advised to keep eye movements at a minimum and to stare straight ahead. Sometimes he is more comfortable with the eyes closed and fixed straight ahead. The less eye movements at the beginning, the more comfortable the patient and the more quickly he will become accustomed to the first insertion of the lenses. Once the lenses are properly placed, 5 or 10 minutes are allowed to elapse before making further observation. Frequently, the patient complains of a foreign body sensation. The examiner should explain to him that there is a foreign body in the eye. When the upper lid is lifted, the patient finds that is where most of the sensation is. A drop of fluorescein or a moistened fluorescein strip can be touched to the sclera above, and with ultraviolet or black light, the fit of the lens on the cornea is observed. If the patient's visual acuity is satisfactory, he is allowed to return in 3 to 5 hours. Again, the eye is stained with fluorescein and the patient is examined under the slit lamp to determine loose or tight areas, the flow of tears between the lens and the cornea, and any possible staining areas of the cornea. If stains are observed, the patient should wear the lenses only a short time. If not, wearing time can begin at 3 to 5 hours and can be increased each day until wearing time is a maximum of 8 to 16 hours. The patient is allowed to remove and replace the lenses several times before he returns home. Printed instructions also are supplied.

Patients are examined at weekly intervals at first, then every 2 weeks, for proper fit and to encourage the patient and to answer his questions. When he has adapted to the lenses, with little tearing and discomfort, it is time for the final refraction. Usually there is no necessity to return the lenses to the laboratory for a change of power.

During this stage of final adaptation, any necessary adjustments are made. It is important to differentiate between normal and true (or abnormal) symptoms. Normal symptoms are adaptive (lid irritation, excessive lacrimation, difficulty in reading, photophobia, lenses falling out, one eye bothering more than the other, and so on.) True symptoms are those that recur in cycles and can be timed (staining, burning, hazing, halo, injection, and hotness). Careful fitting of contact lenses will eliminate most true symptoms. Large lenses or base curves that are too steep will induce early symptoms. A change in the diameter of the lens, the width of the intermediate and peripheral curves, or the base curve will usually eliminate true symptoms, which are the result of excessive tightness. It is only for true symptoms that such adjustments are made. Most of these can be made in the practitioner's office in a few minutes, except for the change in the base curve and change in lens power, which must be done in the laboratory.

Office Equipment

The slit lamp and biomicroscope provide the most valuable information regarding the proper physical fit of a corneal lens. With this instrument the physician can study the flow of tears between the cornea and the contact lens, the relation of the internal curvature of the contact lens to the external curvature of the cornea, areas of touch or bearing of the lens upon the cornea, the relation of the peripheral curves of the lens to the cornea, and most important, areas of cornea staining. Staining may limit wearing time more than any other factor. Its cause must be found and eliminated.

The author prefers to make adjustments in his own office if possible, and has installed his own equipment for this purpose, consisting of contact lens cleaner, buffer and polisher, peripheral curve

and blending tools, and polisher. With this it is easy to reduce the diameter of the lens if needed, to roll the edge slightly if it needs to be tightened, or to open the periphery with 1 or 2 curves and blend the junction to promote greater flow of tears between the cornea and the lens and reduce tightness. Patients appreciate this because it eliminates sending the lens back to the laboratory, which may require a week, and necessitates a second period of adaptation. As a result, lenses are sent back to the laboratory only for changes in the base curve and in power. As the physician becomes more proficient in fitting contact lenses and in selection of patients, his referral of lenses back to the laboratory becomes less.

Conclusions

1. Contact lenses have reached a high state of perfection.
2. Fitting techniques have become greatly simplified.
3. Slight amount of additional equipment is required in the ophthalmologist's office to fit contact lenses properly.
4. Many types of refractive errors and patient personalities are greatly improved and aided by contact lenses.
5. Wearing time has improved to 8 to 16 hours with complete comfort and freedom from danger to the eye.
6. Patient satisfaction is excellent.
7. Patients demand them; ophthalmologists should fit them.

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Pharmaceutical Industry Spends $197,000,000 on Research in 1959

The prescription drug industry disclosed August 1 that it spent $197,000,000 on research and development last year in the biggest privately financed assault on ill health in history.

The expenditure—16 per cent higher than in 1958—amounted to 7.8 per cent of the companies' pharmaceutical sales of more than $2,500,000,000. Drug industry research spending in 1959 was $7,000,000 more than the companies estimated a year ago that it would be.

An estimated 100,200 chemicals, compounds, and other substances were prepared, obtained, and biologically tested by the industry in 1959 in its search for new and more specific medicinals. Of these substances, 36,600 were in the field of cancer chemotherapy. The second heaviest concentration was 28,200 substances pertaining to allergies and infectious diseases.

Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association, said his organization has completed the third annual survey of research activities of the industry in cooperation with the National Institutes of Health. More than $18,000,000 of the total was spent outside pharmaceutical house laboratories in the form of grants and contracts to medical schools, hospitals, research institutes, and other institutions.

Allergy and Contact Lenses

Although allergy management does not improve the condition of the eyes enough to allow wearing of contact lenses over long periods, hay fever is not necessarily a contraindication to the wearing of the lenses. Cases of five hay fever patients are presented.

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THE popularity and widespread use of contact lenses presents new problems to the allergist as well as to the ophthalmologist. Problems are new since their solution is not a ready source of reference in either ophthalmology or allergy textbooks.[4] Because of lack of information in literature and textbooks regarding contraindications for the use of contact lenses, the following cases are considered significant.

Case Reports

CASE 1.—A 39 year old housewife was referred in March, 1959, with chief complaint of irritation and itching of the eyes. She was having nasal discharge and was unable to wear contact lenses for more than 2 hours. She had been fitted with these lenses in September, 1958. She gave a history of seasonal hay fever which was usually worse in the spring and fall. She also had had urticaria and a mild reaction to tetanus antitoxin. Examination revealed conjunctival irritation and increased lacrimation. The mucous membranes of the nose were swollen, pale, and covered with serous secretion. A nasal smear showed 3 per cent eosinophils. Skin tests showed that she was sensitive to house dust, feathers, wool, elm, pecan, mountain cedar, ragweed, careless weeds, and grasses. Patch tests for plastic lens materials, wetting agents, and antiseptic solutions proved negative.

Hyposensitization therapy was given from March 10, 1959, until November 13, 1959. In addition, antihistamines and topical steroids were used. At no time was the patient able to wear her lenses more than 2 hours, although the rhinitis was relieved by treatment.

CASE 2.—A 15 year old female high school student first was seen on August 12, 1958, with chief complaint of inability to wear contact lenses for more than 1 to 2 hours. She had been fitted with contact lenses in July, 1957, and the present pair was her fifth. She complained of excessive mucus, burning, photophobia, and lacrimation. She had had hay fever since August, 1956. This was the first year she had been unable to wear contact lenses. At examination there was conjunctival irritation and increased lacrimation. Mucous membranes of the nose were swollen and pale, and profuse serous discharge was present. A nasal smear showed 14 per cent eosinophils. Skin tests showed sensitivity to house dust, feathers, wool, egg white, citrus, ragweed, careless weeds, grasses, trees, and molds. Patch tests with methyl methacrylate (Lucite-DuPont), using grindings and a plastic plate bathed in secretions from the lacrimal glands, were negative. The patient received continuous hyposensitization treatments. Eggs and milk products were eliminated from the diet and symptoms improved greatly. In spite of the use of long acting antihistamines, topical steroids, and allergy injections, she was unable to wear contact lenses longer than 2 hours daily.

CASE 3.—A 35 year old female physician was seen on March 6, 1959, because of severe hay fever and inability to wear contact lenses. She gave a history of childhood hay fever while she was living in New York. Her symptoms in Texas had been seasonal until recently. She was known to be sensitive to penicillin. She began to wear contact lenses in September, 1958, and had no trouble until January, 1959, a time when the mountain cedar pollen was prevalent. On examination there was conjunctival irritation, lacrimation, and slight edema. Mucous membranes of the nose were swollen and pale, and profuse

serous discharge was observed. Skin tests indicated she was sensitive to house dust, feathers, ragweed, careless weeds, and trees. A nasal smear showed 5 per cent eosinophils. Intensive hyposensitization treatments caused considerable improvement in hay fever symptoms, but she was unable to wear the lenses more than 3 hours daily.

CASE 4.—A 33 year old dentist's wife first was seen on April 2, 1959, with complaints of severe sneezing, nasal discharge, itching of the roof of the mouth, and increased lacrimation. She had been wearing contact lenses since February 12, 1959. In August, 1958, hay fever symptoms became severe and eustachitis developed, resulting in hearing impairment. Examination revealed slight conjunctival irritation, with increased lacrimation. Mucous membranes of the nose were pale, swollen, and a serous discharge was present. Skin tests showed that she was sensitive to house dust, ragweed, mountain cedar, oak and pecan. Nasal smear showed 2 per cent eosinophils. Hyposensitization treatments caused much improvement. At no time did severity of the hay fever interrupt her ability to wear contact lenses 6 to 8 hours.

CASE 5.—A 30 year old female school teacher first was seen on January 2, 1957, with chief complaint of severe hay fever. She had received hyposensitization treatments in 1955 with complete relief of symptoms. There was mild irritation of the conjunctiva. Mucous membranes of the nose were pale and swollen, completely obstructing the nares. A nasal smear showed 30 per cent eosinophils. Skin tests showed sensitivity to house dust, ragweed, mountain cedar, and march elder. Hyposensitization treatment gave excellent relief. The patient began to wear contact lenses in June, 1958, without any symptoms. In August, 1959, and January, 1960, in spite of severe hay fever, she was able to wear contact lenses 6 to 8 hours daily without increased symptoms.

Comment

Of 5 patients reported, 3 were unable to wear contact lenses in spite of oral, local, and allergy therapy. Two patients were not affected by the conjunctivitis associated with hay fever, and they were able to wear lenses 6 to 8 hours daily.

Contact lenses[3] have been used to correct refractive errors, as protective devices, and as an adjunct in the treatment of many eye conditions. These lenses are a valuable aid to vision, especially when wearing glasses is impractical or dangerous. In spite of real indications, the cosmetic effect makes contact lenses more popular. An estimated 70 per cent of users of contact lenses are women.

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Some contraindications to the use of these lenses are well understood. These include minor refractive errors, presbyopia, prepresbyopia, and high prismatic prescriptions. Some medical contraindications such as hay fever never have been evaluated.[1, 2]

Three of our patients were relieved of hay fever symptoms by injections, yet were unable to wear contact lenses without eye symptoms. Two with severe symptoms were able to wear contact lenses in spite of increased lacrimation and nasal obstruction.

A general statement that hay fever is a contraindication for the use of contact lenses is not true. All patients were improved by hyposensitization treatments, but 3 of the 5 could not wear contact lenses for longer periods than before treatment. No patient was sensitive to the plastic lens material, wetting agents, or antiseptic solutions.

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Elimination of many undesirable effects from eye surgery can be achieved by evisceration. Indications and contraindications are enumerated, and the author's procedure for evisceration is described, along with results from 13 cases.

Evisceration of the EYE

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THE PROS AND CONS of evisceration versus enucleation have evoked vigorous discussion for years. Specifically, this paper will discuss modifications, indications, and contraindications for evisceration, and the author's experience with the operation. More detailed accounts of the procedure and its modifications are found in articles by Burch, Berens, A. D. Ruedemann, Jr., and Hughes.

Many types of operations and implants have been devised for evisceration and enucleation. Implants (integrated and non-integrated) have been varied to achieve better cosmetic results and motility after enucleation. Since the conjunctiva and fascia are stretched forward to cover the implant, the fornix is made shallower. This reduces mobility of the implant by obstructing the margins of the prosthesis. According to Hughes, the sunken appearance of the upper lid is related to the shortened upper fornix; others believe that it is related to loss of volume or orbital contents. Another problem of enucleation is that the replacing implant occupies a smaller space than the normal eye. The difference is made up by a heavy prosthesis which stretches the lower lid. Extrusion and displacement of the implant is a disconcerting complication of enucleation.

Elimination or reduction of these undesirable effects is achieved, the author believes, by evisceration. In 1939, Burch reported a type of operation in which the cornea was preserved and an implant was placed inside the sclera. There since have been modifications of the Burch procedure.

Discussion

Three frequently listed arguments against evisceration are: (1) sympathetic ophthalmia, (2) unsuspected intraocular malignant tumor, and (3) loss of material for pathologic examination.

The first is the most feared, but according to A. D. Ruedemann, Jr. there has been no proved case in the literature of sympathetic ophthalmia after a true evisceration. In several questionable cases, uveal tissue was found inside the sclera. This emphasizes the importance of thorough cleansing of the inside of the globe.

There are cases reported by A. D. Ruedemann, Jr. in which an undiagnosed melanoma was discovered at examination of the intraocular contents after evisceration. The eyes then were enucleated. Time will be required to determine if the "cure rate" is less than in those patients who initially have had enuclea-

tion. The point cannot be emphasized too strongly: if there is any question, enucleate. Loss of pathologic material is not a valid argument in view of the type of cases in which evisceration is required. In the author's series, the trauma that made the procedure necessary already had rendered the eye disorganized for pathologic study. In cases in which this has not occurred, the intraocular contents frequently can be removed completely for examination.

Lesser arguments against evisceration include (1) longer recovery period complicated by conjunctival chemosis; (2) extrusion of the sphere implant; and (3) no improvement in the comparative rotation over enucleation. There is a possibility of greater reaction with evisceration, but in the author's experience this has been controlled with lid suturing and application of a pressure dressing. As far as extrusion of the implant, Jardon[5] believes that ill fitting prostheses are responsible in most cases and that the percentage of loss is low. The majority seems to agree that motility is superior.

In favor of evisceration are the following: (1) superior cosmetic appearance with no displacement of the sphere through the muscle cone; (2) avoidance of sunken upper culcus and better motility; (3) beneficial psychological effect on the patient because he still has an eye and only the "insides" have been removed. He accepts the idea of wearing a "contact lens" better than having a "glass eye."

Procedures

In 1939, Burch described a procedure of evisceration in which a circumcorneal incision is made around two fifths of the cornea, leaving a 5 mm. margin of sclera for closure. A small incision in the sclera is made in front of the superior rectus muscle and is extended with scissors. The ciliary body is separated with a spatula, an evisceration spoon is inserted, and the intraocular contents removed completely. Bleeding is controlled; the inside of the sclera is sponged with 1 per cent iodine for 1 minute and then with 70 per cent alcohol. A sphere is introduced into the sclera and the incision is closed with fine white silk mattress sutures. The conjunctiva is closed separately.

Dr. Joe L. Bussey, who practices ophthalmology in Fort Worth, presented this paper before the Texas Ophthalmological Association meeting there on April 12, 1960.

In 1956, Berens, Carter, and Breakey presented their experience with a steel mesh-capped hollow sphere plastic implant. Since others had observed sloughing of the cornea in cases in which this structure had been retained, they removed it. This makes their method essentially a Mules' operation with the addition of a flattened front mesh plastic implant. The flattened front implant, used with a flattened back prosthesis, was designed for better mobility. A. D. Ruedemann, Sr., in 1956 reported a series of 200 cases in which he used a plain plastic sphere implant.[5]

The procedure employed by the author and his co-workers is a Burch type evisceration and is not considered a modification.

1. Anesthesia ordinarily used is retrobulbar injection with 2 per cent xylocaine, wydase, and adrenalin. In addition, a modified Van Lint lid block is performed.

2. A lid speculum is inserted and a 4-0 silk traction suture is placed beneath the superior rectus.

3. The conjunctiva and Tenon's are entered with scissors in front of the superior rectus insertion and incision is extended from 3 to 9 o'clock.

4. The sclera is entered with a Bard Parker knife in front of the superior rectus and about 6 mm. from the limbus. Incision is extended to about 3 and 9 o'clock.

TABLE 1.—*Age and Sex Distribution of Patients Operated Upon.*

Age Distribution	Number Cases
10-15 years	6
20-25 years	2
30-40 years	3
over 50	2
Total	13
Sex Distribution	**Number Cases**
Males	10
Females	3

TABLE 2.—*Reasons for Evisceration.*

A. Trauma—(globe disorganized, no light perception)	
1. Penetrating shell casing	(1 case)
2. Intraocular foreign body—(rotary lawn mower)	(2 cases)
3. Blunt force—(fist and jack handle)	(2 cases)
4. BB shot	(1 case)
B. Phthisis bulbi—(secondary to trauma)	
1. Automobile accident	(2 cases)
2. Sharp instrument penetration	(2 cases)
C. Secondary glaucoma—(resulted from previous trauma)	
1. Eye buphthalmic, ugly but not painful	(2 cases)
D. Uncontrolled and recurrent hyphema after blunt injury	(1 case)

5. The ciliary body is separated with a broad iris spatula and the intraocular contents are removed with an evisceration spoon.

6. The inside of the sclera is cleansed carefully to remove all uveal tissue. Bleeding is controlled with heat cautery. The endothelium is curetted and cleaned with a gauze sponge.

7. A solid plastic ball is inserted into the sclera. Size varies, but the consensus is that an 18 mm. ball is the desirable size for good cosmetic results. The sphere should fit loosely to allow for some shrinkage of the sclera, permitting adequate room for the prosthesis.

8. The sclera is approximated edge to edge by various types and methods of sutures. Generally, the author uses a running 4-0 chromic suture with some interrupted sutures.

9. The conjunctiva is closed with a running 5-0 plain gut suture.

10. The lids are closed with two 4-0 black silk sutures placed over rubber dams.

11. An antibiotic ointment is placed on the lids and a pressure dressing with a head bandage is applied. Dressing is not changed until the fifth day unless necessary.

12. Systemic antibiotics are given the first 2 to 3 days. The patient is ambulatory the day after surgery, and is discharged from the hospital usually on the fifth day after the dressing is changed to a simple pressure patch. Lid suturing and pressure dressing controlled chemosis satisfactorily.

13. Lid sutures are removed by the second week or earlier. Usually the prosthesis is fitted by the second month postoperatively.

Results

This series is small, only 13 cases, and the time of follow-up observation is less than 1 year. Table 1 shows the age and sex distribution and Table 2 indicates the conditions which required evisceration. Trauma was involved in all cases.

The only complication was in Case A-1 (Table 2) in which there was a breakdown of the wound. First impression was that the 18 mm. sphere was too large, and it was replaced with a 16 mm. sphere, but without improvement. The author believes now that breakdown resulted from loss of tissue at the limbus, due to injury (which at the time was not considered). This was repaired satisfactorily with a conjunctival flap.

The author's experience with this method of evisceration concurs with that of others in that the procedure offers better cosmesis, and motility, less irritation, less discharge, and better patient acceptance. It is too early to comment on the possibility of extrusion of the implant. The time period of greatest concern has passed without occurrence of sympathetic ophthalmia.

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Therapeutic Use of Radioactive Iodine in Heart Disease

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Radioiodine therapy affords a safe, certain, usually permanent, and reasonably prompt method of depressing thyroid function and thereby more or less permanently altering the circulation. Its use is indicated in essentially 3 types of patients with cardiac disease: those with hyperthyroidism (the thyrocardiacs), those with intractable angina pectoris or congestive failure but with normal thyroid function, and those with cardiac arrhythmias but with normal thyroid function.

A CLOSE RELATIONSHIP between thyroid function and cardiac function, long recognized, has recently been measured by direct methods.[3, 12] Radioiodine therapy offers a safe, certain, usually permanent, and reasonably prompt method of depressing thyroidal function and thereby more or less permanently altering the circulation. Radioiodine therapy seems indicated in essentially 3 types of patients with cardiac disease:

1. In patients with simultaneous hyperthyroidism and cardiac disease (thyrocardiacs) such therapy affords an essentially risk-free means by which thyroid function is permanently reduced to normal.

2. In selected euthyroid patients with intractable angina, intractable congestive heart failure, or both, it may be used to produce therapeutic hypometabolism; systemic circulatory requirements are thereby reduced to within the limit of a diminished cardiac reserve.[1, 6]

3. In certain euthyroid patients with cardiac arrhythmias, especially of supraventricular variety, intractability to treatment may be reduced by production of therapeutic hypo-metabolism with radioactive iodine.

Except for the effect on cardiac arrhythmias in the euthyroid individual, the basic effect of circulating thyroid hormone upon cardiac function is relatively simple. As the level of thyroid function is raised, the work of the heart is increased, largely by an increase in cardiac output. At relatively low levels of cardiac output this effect is mainly on the pressure factor of the cardiac work equation and is consequently a direct proportion. At high levels of cardiac output an increase in cardiac output may disproportionately increase the work load of the heart because it enters the kinetic factor of the cardiac work equation as a geometric function. Graettinger and co-workers[3] made actual measurements of the cardiac output in patients with hypothyroidism and compared them to normal subjects under like conditions using data obtained at right heart catheterization. In normal subjects they found a resting

cardiac index of 2.92 L./min./m² compared to 1.88 in hypothyroid subjects. This represents approximately a 35 per cent decrease in cardiac output. Similarly the cardiac output with exercise was 4.42 L./min./m² in normal subjects compared to 3.05 in hypothyroid subjects. Myers and associates[12] found an average resting cardiac index of 5.24 in patients with hyperthyroidism compared to 3.97 in normals.

When it seems necessary to decrease thyroid function in the therapy of patients with cardiac disease, radioactive iodine given in an appropriate manner for the individual treated seems the method of choice. It is free from the usual risks of surgery and may be used in both hyperthyroid and euthyroid patients. The iodides and antithyroid drugs (thiourea derivatives) may be used in hyperthyroid individuals, but it is extremely difficult to produce hypometabolism in a euthyroid patient with these medications.

Since dosage schedule and treatment methods vary in the thyrocardiac, in the euthyroid patient with intractable heart disease, and in the euthyroid patient with arrhythmia, these three categories of disease will be considered separately.

Hyperthyroidism with Heart Disease—The Thyrocardiac

The association of thyrotoxicosis and heart disability, reported by many investigators,[2, 5, 7, 13] is usually referred to as thyrocardiac disease. Most frequently thyrotoxicosis aggravates concomitant heart disease. Consequently, it has been suggested[10] that all thyrocardiacs have some form of underlying heart disease unrelated to thyrotoxicosis. Nevertheless, in some cases no form of heart disease was apparent and cure of toxicity resulted in normal cardiac status.

The authors reviewed data of their hyperthyroid patients for evidence of heart disability. Only patients treated with radioiodine were included. Patients with major aberrations in rhythm, cardiomegaly, congestive heart failure, angina pectoris, or any combination of these were classified as thyrocardiacs.

Of a total of 306 hyperthyroid patients, 78 (25 per cent) had evidence of heart disease. The majority (60) had diffuse toxic goiter (Graves disease); 18 manifested toxic nodular goiter. There were 64 females and 14 males with ages ranging from 20 years to 89 years (Table 1). Congestive failure was the most prevalent cardiac abnormality in this group, being present in 70 cases (90 per cent) (Table 2).

TABLE 1.—*Age of Thyrocardiacs—78 Patients.*

Age	21-30	31-40	41-50	51-60	61 and over
No. of cases	1	12	20	22	23
% of cases	1	16	26	29	31

Often it was associated with some other abnormality. Major rhythm disturbance was noted in 25 patients (32 per cent), with auricular fibrillation occurring in 18, auricular flutter in 1, and paroxysmal auricular tachycardia in 5. Angina pectoris was present in only 3 patients. This accorded with the observation of Haines and Kepler,[4] who believed that it was a rare complication of thyrocardiac disease.

TABLE 2.—*Cardiac Manifestations in 78 Thyrocardiac Patients.*

Manifestation	No. of Cases	% of Total
Congestive failure	70	90
Atrial fibrillation	18	23
Atrial flutter	1	1
Supraventricular paroxysmal tachycardia	5	6
Frequent premature systoles	1	1
Angina pectoris	3	4

Heart disease of organic etiology other than thyrotoxicosis was demonstrable in 45 patients. In 33 the heart disability appeared to be solely a manifestation of the toxic thyroid. This suggested that significant cardiac disability was either the result of thyrotoxicosis alone or that heart disease was not detectable by usual clinical methods. Post treatment follow up evaluations of 6 months or more were available in 68 cases with average group follow up period of 4 years.

Control of hyperthyroidism followed a single therapeutic dose ranging from 3.5 millicuries to 30 millicuries of radioiodine in 52 of 72 thyrocardiac patients with adequate follow up evaluations. Fifteen received 2 doses, 2 received 3 doses, and 3 required more than 3 treatments. Patients with toxic nodular goiter generally received the largest amounts of radioiodine; the largest total dose per individual was 104 millicuries. In 22 patients (28 per cent) myxedema developed. All but one of these had diffuse toxic goiter. The myxedema, however, proved advantageous in several cases of severe organic heart disease in which maintenance of the euthyroid state did not ameliorate distressing symptoms. Adjustment of therapy so that patients were mildly hypothyroid caused symptomatic improvement.

Response to therapy was gratifying. Before radioiodine treatment 64 patients had symptoms of progressive severity, 10 had stationary symptoms, and 4 had improved as a result of antithyroid drug use. Approximately one-third manifested severe heart failure (functional class III or IV). In all but 7 of the patients with any degree of heart failure (Table 3) there was significant symptomatic improvement after correction of thyrotoxicosis. All who failed to improve in the early post treatment period had severe arteriosclerotic or hypertensive cardiovascular disease. Two patients died during the post treatment period.

Only 4 of those with major aberrations of rhythm had persistence of arrhythmia (3 with fibrillation and 1 with paroxysmal tachycardia) after radioiodine treatment. One of the 3 patients with angina pectoris

TABLE 3.—*Improvement After Radioiodine Therapy in Thyrocardiacs—78 Cases.*

	Excellent	Fair	None	Worse
Congestive failure	42	15	7	0
Arrhythmia	21	0	4	0
Angina pectoris	2	0	1	0

continued to have anginal pain. Hypothyroidism developed in this patient with post treatment angina. He was given 2 grains of dessicated thyroid, but continued to have attacks of anginal pain. Unfortunately, further follow up examination was not obtained. Therefore, it is not known whether reduction of thyroid dosage to mildly hypothyroid levels would have ameliorated the angina, though presumably it would have done so. Several of the patients with severe congestive failure, protracted peripheral edema, pleural effusion, and cardiac enlargement had total relief of manifestations of heart disease after treatment.

Though a few patients showed slight deterioration of the cardiac disability in the immediate post treatment period, this was insignificant. Several severely ill patients, however, were given small multiple therapeutic doses to avoid the possibility of releasing excessive amounts of thyroxine into the circulation.

Of considerable interest was the discovery by means of tracer studies of "masked" hyperthyroidism in 5 patients with signs and symptoms of advanced cardiac disease. These patients were benefited greatly by radioiodine therapy.

Euthyroid Cardiacs with Intractable Angina Pectoris and Congestive Failure

Several groups of investigators have demonstrated the value of therapeutic hypometabolism produced by thyroid suppression with radioactive iodine in the therapy of euthyroid cardiac patients with intractable congestive failure and intractable angina.[1, 6] The rationale is as aptly described by Blumgart:[1] "that lowering the total metabolism of the body so reduces systemic circulatory requirements as to place them within the limits of cardiac reserve." This appears to be the mechanism by which relief occurs: the patient treated with I^{131} has as much organic cardiac damage after treatment as before. Thus, radioiodine therapy should be only a part of overall therapy of patients with intractable angina or failure.

Certain rigid criteria for selection of patients for treatment, for example, the requirement of Blumgart that cardiac status be stationary for 1 year, were probably propounded to evaluate accurately the radioiodine method *per se*, and not necessarily to enable salvage of the largest possible number of patients. The essential criteria for selection of patients in the present series was angina or failure or both, sufficiently severe to incapacitate the individual from activity required by his daily life in spite of the most rigid medical measures possible. Progressive deterioration, unless precipitous, was not considered a contraindication to radioiodine therapy. In fact, some of the most dramatic results occurred in such cases. No patient was treated whose condition was degenerating so fast that death was expected before the usual 4 to 6 weeks required for thyroid suppression. The 40 euthyroid cardiac patients with intractable angina or failure selected for radioactive iodine therapy included 7 patients with intractable angina, 16 patients with intractable congestive failure, and 17 patients with both angina and failure.

Dr. Earl F. Beard, Houston internist, presented this paper before the Section on Internal Medicine of the Texas Medical Association on April 12, 1960.

Ages varied from 42 to 77 years, and duration of symptoms from 8 months to 12 years. The functional cardiac class of all patients was either III or IV; that is, symptoms were present either at complete rest or during little exertion. Etiologic diagnoses were coronary artery disease or arteriosclerotic heart disease in 31, rheumatic heart disease in 6, and cor pulmonale secondary to emphysema in 3. Pretreatment thyroid function was normal in all cases on the basis of clinical evidence and normal 24-hour thyroidal uptake of I^{131}.

Although dosage schedules varied, radioiodine was usually given in divided doses in this group. The most frequently used schedule was 10 millicuries weekly for 3 doses as advocated by Blumgart and associates. Additional doses were given if thyroid suppression was inadequate, that is, if 24-hour thyroidal uptake of a tracer dose of I^{131} was more than 10 per cent. Average total dose of radioiodine administered was 34.8 millicuries (range 6-60). In 4 patients exacerbation of angina occurred after single doses of 15 millicuries or more (Table 4). In all cases the patient's usual cardiac regimen was continued during and after treatment, except that frequently it was possible to reduce the amounts of medica-

TABLE 4.—*Effect of I^{131} Therapy in 57-Year-Old Man with Angina.*

Date	Pulse Rate	Blood Pressure	P.B.I.	Angina at Rest
3/ 6/59	70	130/80	5.0	+
3/ 7/59*	74	140/80	..	++
3/ 8/59	86	142/90	5.0	+++
3/ 9/59	94	180/90	7.8	++++
3/10/59	80	136/90	6.1	+++
3/11/59	76	130/90	5.4	+
3/12/59	76	140/80	5.4	+
3/13/59	80	130/90	4.9	+
3/14/59	80	130/80	5.4	+

*I^{131}, 28 mc., administered.

tion or to allow more activity after thyroid suppression. No complications occurred when patients received anticoagulant therapy simultaneously; that is, there was no clinical evidence of hemorrhage into the thyroid with any individual dose given.

Duration of follow-up study ranged from 1 to 51 months. Results of treatment are illustrated in Tables 5 and 6. Thirty-five patients improved 1 or more

TABLE 5.—*Results of I^{131} Therapy in Euthyroid Patients with Angina and Congestive Heart Failure.*

Improved 2 functional classes	9
Improved 1 functional class	26
Unimproved	3
Died before any effect	1
Lost to follow-up	1
Worsened	0
Total	40

functional cardiac classes, 3 remained in the same functional cardiac class as before treatment, 1 died before any effect occurred, and 1 was lost to follow-up. When radioiodine was given in carefully divided doses, no patient was permanently worsened by it. This seems in accord with the statement by Graettinger and others[3] that in hypothyroid individuals the physiologic protection afforded by decreased circulatory demands overshadows any possible changes in the myocardium.

Table 6 illustrates treatment results in a slightly different way. Of the patients treated 37 were able to increase their activity after treatment, or they had symptomatic relief though they were not able to increase activity. Previous results for symptomatic

TABLE 6.—*Symptomatic Relief After I^{131} Therapy in Euthyroid Cardiac Patients.*

	Patients with Angina	Patients with Failure	Patients with Both
Good results*	7	14	14
Fair results**		1	1
Unchanged		1	1

*Patients were able to increase activity after treatment.
**Some relief of symptoms although patients could not significantly increase activity after treatment.

relief are given without regard for mortality. Of the patients treated, 17 (43 per cent) are dead (15 of cardiac and 2 of noncardiac causes). As may be inferred from this data, many patients who died of a cardiac cause received some measure of symptomatic relief after radioiodine treatment. Several were completely unmanageable outside the hospital before treatment but became comfortable at rest or during some degree of activity at home. The mortality rate of patients with coronary artery disease treated with radioiodine is interesting though the series is still too small to be statistically significant (Table 7). Of 13 patients given long term anticoagulant therapy, 10 were alive and 3 dead (1 of noncardiac, 2 of cardiac cause) at last follow-up examination. In contrast, of 13 patients who did not have anticoagulant therapy, 5 were alive and 8 dead (only 1 of noncardiac cause) at last follow-up report. Patients receiving long term anticoagulant therapy now account for 157 patient months of life after

TABLE 7.—*Mortality (At Last Follow-up Examination) of Patients with Coronary Artery Disease.*

	Alive	Dead
13 taking anticoagulants	10*	3 (1 accidental)
13 not taking anticoagulants	5**	8 (1 of malignant disease)

*Accounted for 157 patient months of life.
**Anticoagulants accounted for 81 patient months of life.

I^{131} therapy, whereas those not receiving anticoagulants account for 81 patient months of life.

In 15 patients (38 per cent) myxedema after treatment required supplementary thyroid, usually ¼ grain desiccated thyroid daily. Average serum cholesterol of 26 patients before treatment was 239 mg./100 cc., and that of 18 patients after treatment 216 mg./100 cc. There is little difficulty controlling serum cholesterol after radioiodine therapy if clinical myxedema is avoided and suitable low-fat diets are used.

From the previously mentioned results, it seems that radioiodine therapy is a useful adjunct in the treatment of the euthyroid patient with intractable cardiac disease and that it has a place in the overall therapeutic regimen for such patients.[1, 6] Apparently the only purpose accomplished by radioiodine therapy is to allow the patient to function within a diminished cardiac reserve. One must look elsewhere for measures to prolong life. The mortality rate of approximately 40 per cent in the present series is similar to that noted by Jaffe.[6] Since the value of long-term anticoagulant therapy is established for reduction of mortality from thrombotic episodes,[8, 11] this type of treatment should be used in combination with I^{131} therapy when the cause of angina or failure is coronary artery disease.

Euthyroid Patients with Cardiac Arrhythmias

Kurland and his associates[9] found an increased erythrocytic uptake of I^{131}-labeled triiodothyronine in some patients with supraventricular tachycardias. The authors therefore made a few trials of thyroidal suppression in apparently euthyroid patients with stubborn arrhythmias of supraventricular origin.

In the present series 3 euthyroid patients with intractable cardiac arrhythmias were treated with radioiodine. Though in 2 of these some degree of failure developed during episodes of arrhythmia, all 3 were essentially symptom-free during periods of sinus rhythm. Two patients had paroxysmal supraventricular tachycardia which could not be prevented by any of the usual therapeutic measures and which was difficult to convert to normal rhythm. In 1 patient without apparent heart disease but with paroxysmal atrial fibrillation and repeated embolization, sinus rhythm could not be maintained before radioiodine therapy. In all 3 arrhythmia could be prevented after therapeutic hypometabolism was induced, either without medication or with prophylactic doses of quinidine. In this small group, however, thyroid function has had to be maintained at nearly myxedematous levels for adequate control. Dosage of supplementary thyroid must be carefully regulated after such treatment. These patients often have no paroxysms if they are kept at near myxedematous levels on a quarter of a grain thyroid daily, but arrhythmia develops as soon as thyroid dosage is raised only to one-half grain daily. The authors believe that in the euthyroid patient with unmanageable cardiac arrhythmia of supraventricular origin, radioiodine therapy can render the condition manageable. It should, however, be used only as a last resort, since in this group, myxedema or near-myxedema is usually the price to be paid for relief from arrhythmia.

Summary and Conclusions

Of 349 patients treated with radioactive iodine, 121 (35 per cent) had cardiac disease. These included 78 thyrocardiacs, 40 euthyroid cardiac patients with intractable congestive failure and/or angina, and 3 euthyroid patients with intractable arrhythmia of supraventricular origin.

Experience with these patients has caused the authors to conclude that:

1. Radioiodine therapy is a safe, certain, and relatively prompt method of permanently reducing thyroid function in the thyrocardiac patient. It is, therefore, the treatment of choice, if carefully administered.

2. In the euthyroid patient with intractable angina and/or congestive failure, therapeutic hypometabolism produced by radioiodine may be a useful adjunct in treatment. It is relatively safe if (a) I^{131} is given in small divided doses and (b) post-treatment clinical myxedema is avoided. Post-treatment thyroid therapy must be carefully regulated. Patients with arteriosclerosis and coronary disease should probably receive anticoagulant therapy routinely after treatment.

3. Certain euthyroid patients with unmanageable arrhythmias of supraventricular origin may be made more amenable to treatment after I^{131}-induced hypometabolism, but usually must be kept at myxedema or near-myxedema levels. In this group radioiodine therapy seems indicated only as a last resort.

4. Careful evaluation of all patients with advanced cardiac disease is advisable to ascertain that masked hyperthyroidism is not overlooked.

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ABSTRACT OF DISCUSSION

Dr. Milton R. Hejtmancik, Galveston: Dr. Beard and associates have called attention, in detailed and statistical form, to a type of therapy which probably has been used too seldom in the management of cardiac patients. In the first group of patients—those with hyperthyroidism and heart disease—there can be no disagreement in regard to the importance of recognition of thyrotoxicosis as a complicating factor in cardiac symptoms, and the need to relieve hyperthyroidism in alleviation of clinical manifestations. Most patients who have congestive and anginal failure as a complication of hyperthyroidism seem to have an underlying cause of heart disease—either hypertension, coronary atherosclerosis, or both. The question has been raised as to whether thyrotoxicosis alone can produce congestive or anginal failure. It is probably uncommon as a sole cause, but I believe it can be. The most convincing proof of this might be the patient with uncontrolled atrial fibrillation caused by hyperthyroidism who has congestive failure as a consequence of rapid, irregular ventricular rhythm.

Dr. Beard and his associates mentioned the rare instances in which radioactive iodine temporarily aggravates anginal or congestive failure through excessive liberation of thyroxine by deteriorating thyroid cells. In such patients, who are in a borderline state, I have usually chosen to administer such thyroid suppressants as propylthiouracil or Tapazol, and later radioactive iodine.

The value of radioactive iodine therapy in the refractory euthyroid cardiac patient is more controversial. As pointed out by the authors, use of radioactive iodine is by no means a substitute for careful medical management, and should be considered only when an intensive therapeutic regimen has failed. In patients with congestive failure whom I have treated, most favorable results have occurred in those with pulmonary heart disease. The effectiveness of therapy has not been as convincing in patients with heart disease of other causes. It has been used in some patients with severe coronary insufficiency after all other measures had been exhausted, occasionally with beneficial symptomatic results. Temporary aggravation of angina immediately after administration of radioactive iodine is possible unless the patient is first treated with other thyroid suppressants. Another disease, hypothyroidism, is substituted for alleviation of present cardiac symptoms. I am not convinced that blood cholesterol is not elevated after such therapy. In patients with angina prolongation of life is not claimed, merely relief of symptoms.

Most patients with recurrent cardiac arrhythmias can be improved by usual medical means, but occasionally a patient is refractory to all measures. Studies demonstrating increased red cell uptake of I^{131}-labeled triiodothyronine in apparently euthyroid patients with paroxysmal arrhythmias would offer strong support to treatment of such patients with radioactive iodine. Although I have had limited experience in this regard, I would use it if arrhythmias could not be controlled by the usual measures.

Physicians who see and treat heart disease occasionally are frustrated by failure of the patient to respond to intensive treatment. Dr. Kelsey and his colleagues emphasize that the complication of hyperthyroidism in such patients could explain refractoriness. Even in euthyroid patients, persistence of symptoms despite usual therapeutic measures requires consideration of thyroid-suppressing therapy. Occasionally, results in such cases are gratifying.

Cultivate Peaceful Concentration, Philosopher Osler Recommended

{The following quotation by Sir William Osler, physician, teacher, and classical scholar, is from an address the philosopher gave to Yale undergraduates, April 20, 1913, entitled, "A Way of Life."}

"Control of the mind as a working machine, the adaptation in it of habit, so that its action becomes almost as automatic as walking, is the end of education—and yet how rarely reached! It can be accomplished with deliberation and repose, never with hurry and worry.

"Realise that you have sixteen waking hours, three or four of which at least should be devoted to making a silent conquest of your mental machinery. Concentration, by which is grown gradually the power to wrestle successfully with any subject, is the secret of successful study. No mind however dull can escape the brightness that comes from steady application. There is an old saying, 'Youth enjoyeth not, for haste'; but worse than this, the failure to cultivate the power of peaceful concentration is the greatest single cause of mental breakdown.

"Plato pities the young man who started at such a pace that he never reached the goal. One of the saddest of life's tragedies is the wreckage of the career of the young collegian by hurry, hustle, bustle and tension."

With the use of a Polaroid land camera and a home constructed glass-topped box containing a fluorescent tube, personnel with no previous training in photography can copy roentgenograms or documents within minutes.

A Simple Device For Rapid Copying of *Roentgenograms*

WILLIAM C. OWSLEY, JR., M.D.
Houston, Texas

FOR the past year we have been using a simple device in our radiological office for rapid copying of roentgenographic films with the Polaroid land camera. It has some advantages over commercially available roentgenogram copiers and may interest physicians desiring small prints to file with their patient records or lantern slides for use in lectures and conferences. With it, paper prints can be made in about 2 minutes, and finished 3¼ by 4 inch lantern slides can be produced in about 10 minutes. Designed primarily to be operated by office personnel or technicians with no previous training in photography, the device accomplishes accurate focusing and centering with minimal difficulty.

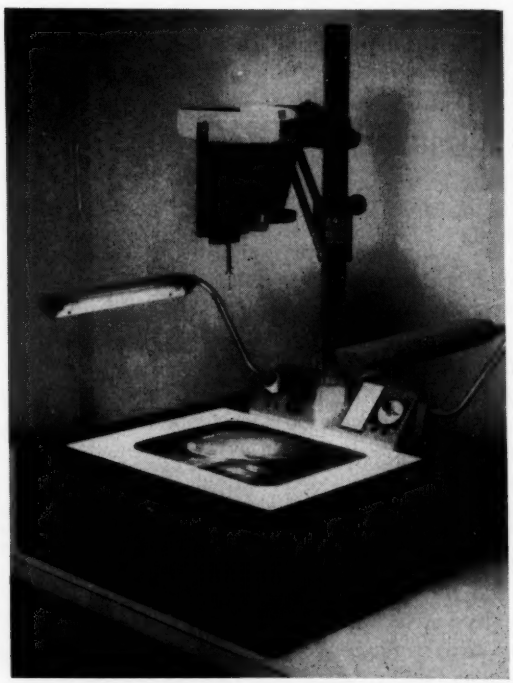

Fig. 1. Author's device for rapid copying of roentgenographic films.

Construction

A Polaroid Number 208 Copymaker, available at a retail price of $99.50, is modified by replacing its plywood base with a homemade glass-topped box that contains a circular fluorescent tube. This provides a source of transmitted light in addition to the reflected light sources furnished with the unit.

The author's light box is made of ¾ inch plywood, with outside dimensions of 7 by 21 by 22 inches. The glass portion of the top measures 14 by 17 inches. The copymaker is attached easily to the box with 2 screws, and the fluorescent tube is wired into the copymaker base through a toggle switch. A drawer in the back of the box provides handy storage space for extra film.

Any of several available models of the Polaroid land camera are satisfactory. The camera is detachable from the stand so that it can be used for ordinary photography, and when reattached to the arm it is centered automatically to the glass portion of the light

box top. The copymaker incorporates an exposure and development timer, the necessary supplementary lenses and filter, plastic focusing screen, exposure charts, masking device, a copyboard marked to show the areas copied at various camera settings, and operating instructions. In modifying the unit, these features need not be disturbed; therefore, it can also be used to make prints or slides of drawings, photographs, small specimens, and so on.

Use of a horizontal light box eliminates the need for clips to hold the roentgenogram during exposure. The film can be moved about on the box so that any part of it is centered, giving a range from coverage of a 14 by 17 inch roentgenogram on a 3¼ by 4¼ inch print down to a 1:1 reproduction of a small area of interest. The arrangement also requires less space than equipment utilizing a vertical light source.

Procedure

For copying documents by reflected light, the instructions furnished with the unit are followed. The copyboard is laid on top of the light box to determine centering and area of coverage. For copies of roentgenograms, the same procedure is followed except that the copyboard is replaced by a piece of clear film marked with various sized rectangles. Proper placement of the copyboard or clear film is assured by guide lines at the edges of the glass top. The radiograph to be reproduced is moved beneath the clear film until the desired area is included within one of the marked rectangles. The rectangle selected determines camera height and focus, which is read from a small card fastened to the base of the copymaker. The clear film then is lifted off the light box, exposure made, and copy developed and coated. This entire procedure takes about 2 minutes in the case of paper prints, using PolaPan 200 film, type 42. Exposure time is 6 seconds for normal density roentgenogram, and development time remains constant at 1 minute. For lantern slides, using type 46 L transparency film, development takes 2 minutes, and a little additional time is needed to coat the film and mount it in a slide frame. At retail prices, cost of prints is about 25 cents each, and of slides, about 95 cents, including mounts.

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Myositis Ossificans of the Humerus (Blocker's Disease)

The author has observed many football players with myositis ossificans on the anterolateral aspect of the humerus at or near the deltoid insertion. Because injury that causes the condition is incurred during blocking, he has termed the process "blocker's disease."

EDWARD T. SMITH, M.D.
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DURING THE PAST several years the author has examined a number of football players with myositis ossificans on the anterolateral aspect of the humerus at or near the deltoid insertion.

Dr. Lent C. Johnson of the Armed Forces Institute of Pathology at Walter Reed Hospital, Washington, D. C., has a theory regarding the formation of myositis ossificans. His theory is that tissue is damaged to the degree that certain chemical changes within the cells during repair result in deposition of calcium products. These products later ossify. He notes that this same process can be found in tissues other than muscles such as tendons, and even in the fatty layers, and is not necessarily related to bone.[2]

I have observed that most football players with myositis ossificans are line men, who do most of the blocking during development of a play, and fullbacks, who lead the blocking from the backfield position. The injury is caused during blocking; therefore, I have coined the term "blocker's disease."

The mechanism of the injury is that the upper arm is thrown out just as contact is made, and it strikes the opponent's helmet, shoulder pad, face guard, or other nonresilient part of his equipment. Rule 9, Section 4, Article 4 of the official National Collegiate Athletic Association Football Handbook[3] has to do with the position of the offensive player's hand and arm while blocking:

> "When a teammate of a Runner or Passer uses a hand or forearm in blocking or to supplement a shoulder or chest block the hand must be in contact with his body and the hand and arm must be kept below the shoulders of the opponent throughout the entire block."

Fig. 1. Photograph of actual practice shows how injury resulting in myositis ossificans of anterolateral aspect of humerus at or near deltoid insertion may be incurred.

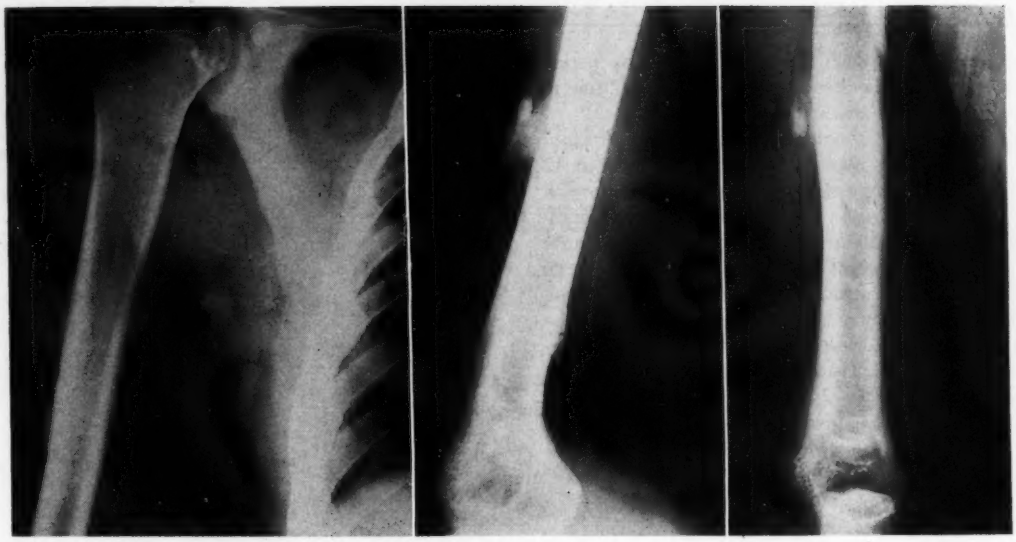

Fig. 2. Calcification in 3 cases. In first 2, mass is attached to humerus; in last, it is loose within soft tissue.

The player may have his hand in contact with the body, but at the instant of impact the blocker throws his elbow out instead of completing the block with his shoulder. In this same article of the rules it is stated that "in a crab or body block it is not required that the hand or arm be in contact with the body." In this instance when the hand is down by the side, if the block it not led with the shoulder, the upper arm is vulnerable for a blow (fig. 1).

The pathogenesis is an injury to the tissue at or near the deltoid insertion. In this region there is less muscle protection over the humerus. If the injury is sufficient to damage the tissue, according to Johnson's concept, chemical changes occur, and after about 3 weeks a faint deposit of calcium can be seen on the roentgenogram. The process is similar to that seen in injuries to the medial collateral ligament of a knee which results in Pellegrini-Stieda's disease.[1] Once calcium has started forming, it usually progresses to ossification. This ossified mass may become attached to the humerus, or it may remain free in the soft tissues (fig. 2).

The first consideration of treatment is prophylaxis. This should be of special interest to physicians attending football players, team trainers, and coaches. Explanation of the mechanism of injury may prevent many of these cases. The football player should be taught the proper method of blocking with his shoulder and should be cautioned not to lead with his arm. If a player persists in throwing his arm forward to increase the effect of his block, some form of protection over the vulnerable aspect is advisable. A protective pad similar to those used over shins, knees, and forearms can be constructed with materials available in most equipment rooms. Any protective pad used must satisfy the rules regarding protective materials, yet application of the pad must not hamper the blocker's activity.

Once injury has occurred, protection to prevent reinjury is needed. Repeated trauma in the early stages of disease will tend to aggravate the condition. True ossification of the calcified mass does not occur for several months. As soon as the condition is suspected—and this is possible in some cases before calcification occurs—proper protection of the area may cause the calcified mass to shrink and may prevent symptoms that require further treatment. I have not treated any of these patients with roentgen therapy because all my cases were seen

Dr. Edward T. Smith, M. D., Houston orthopedic surgeon and president of the Texas Society of Athletic Team Physicians, presented this article to the Society on April 18, 1959.

late. Nevertheless, such treatment in the early period would probably be beneficial, as has been true in Pellegrini-Stieda's disease.[1]

Early operation should never be considered. Until the calcified mass matures, which may take 6 to 12 months, no attempt should be made to remove it surgically. Many times these areas become asymptomatic when the bone matures. Only when the mature bone causes symptoms should surgical treatment be considered. If the area of myositis ossificans is loose within the soft tissue, careful sharp dissection of the bony mass is sufficient; figure 3 shows such a specimen after removal. However, if the mass is attached to the humerus (fig. 2) and forms a painful spur, it should be removed with a wide base of normal tissue. Otherwise, the condition may recur.

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Fig. 3. Photograph shows gross specimen dissected from soft tissues.

A Multicounty Health Department

The developmental trend of multicounty health departments in Texas is traced briefly. The author believes that the principle is sound and that further expansion and refinements should be encouraged.

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A MULTICOUNTY health department, as the name implies, is defined as a health department operating as a unit which contains more than one county. In Texas, there are departments consisting of two or more counties and in two instances, such units have had as many as five counties each.

Populationwise, 75 per cent of the state is covered by an organized basic local-state participating public health departments. There is partial coverage in many communities by sanitarians and nurses working more or less independently, but without adequate medical supervision. In Texas, there still are large sparsely populated areas with practically no routine local public health services. Such areas could well obtain these services by being included in a multicounty health department.

In 1945, the Haven Emerson Report, "Local Health Units for the Nation," the subcommittee on local health units and the committee on administrative practice of the American Public Health Association, proposed a plan for complete coverage of the United States with units rendering basic, minimal full time services. These include vital statistics, communicable disease control, environmental sanitation, public health laboratory services, maternal and child health, and public health education. The report recommended that 1,197 units be formed in the then existing 48 states, containing 3,070 counties.

The committee is of the opinion that a present goal should be the creation of such number and boundaries of areas of local health jurisdiction in every state to bring within the reach of every person and family the benefits of modern sanitation and personal hygiene. Such a program should be under the guidance of trained professional and accessory personnel employed on a full time basis at public expense, selected and retained on a merit or civil service basis and free from the influence of partisan politics.

Resolutions endorsing the establishment of full time local health units to serve every area and unit of population were made by the American Medical Association's House of Delegates, June 10, 1942; the American Public Health Association's Governing Council, October 29, 1942; and State and Provincial Health Authorities of North America Conferences, March 22, 1944.

The report recommended that Texas, with its 254 counties, be divided into 80 units varying in size from one county with a major city and metropolitan area to as many as 10 counties in sparsely populated areas.

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In 1942, Texas reported 43 units in 64 counties, or parts of counties, with full time local health services. In 155 counties, accounting for nearly two-thirds of the state's population no local health service was reported. Twenty-seven counties reported a venereal disease clinic or part time nursing service.

The cost per capita for local health services was 40 cents in 1942. At that time it was estimated that $1.00 per capita would pay for the aforementioned basic services.

The 1960 census should reveal some interesting facts in population trends. Needs should be reevaluated, and, with changing values of money, the cost of the program.

Permissive legislation for formation of a multicounty health department is found in the Public Health Laws of Texas—Article 4447a—"a coordinated health program." It reads as follows: "The commissioners court of any one or more counties and the municipal authorities of any one or more cities, towns, school boards and school districts, and any other governmental entity may cooperate in the establishment of a coordinated health program and by mutual agreement, may provide for the payment of costs, including the salaries of persons employed, materials used, and the provision of suitable office quarters, health and clinic centers, health services and facilities therefor, and for the maintenance purposes." (Acts, 1949, Fifty-first Leg., p. 107, ch. 63, s. 1.)[1]

Economy of operation is the main advantage of the multicounty health department. A thinly populated area can receive public health services of good quality by sharing personnel (clerk, nurse, sanitarian team, and medical supervisor) with a similar area, whereas neither region could conduct or underwrite the expenses of the program alone. Guidance from the state division of local health services is instrumental in maintenance of high standards of service.

Because of distances, unit cost of service is probably higher than where there is a more concentrated population, and the cost will be reflected in increased travel expense. This might be considered a disadvantage, but unquestionably is offset by the advantages.

The most recent development in providing for the formation of multicounty health departments is Senate Bill 206, passed by the Fifty-sixth Legislature, effective May 26, 1959. This legislation permits appropriating bodies of different governmental entities to cooperate and form a district for health department services. It also clarifies the often confused status of the health department director's authority in enforcement of public health laws, particularly that pertaining to quarantine. It enables the director of a multicounty department to act as health officer in more than one city and/or county and facilitates enforcement of public health laws.

I believe that the principle of the multicounty health department is sound and that further expansion and refinements in this type of program should be encouraged.

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Acute Ruptured Appendicitis and Incarcerated Inguinal Hernia In Premature Infant

Association of a perforated appendix and incarcerated inguinal hernia is uncommon. In a 7 week old infant, recovery ensued.

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Big Spring, Texas

A RECENT CASE of perforated appendicitis contained in an incarcerated inguinal hernia has stimulated the author's interest. Coley[3] reported 1.35 per cent of herniated appendices in 2,000 personal cases. Watson[14] found 512 cases of hernia involving the appendix in the literature; 269 of these were of inguinal and 217 of femoral hernia. In 1731 De-Garengeot[4] first described an inguinal hernial sac that contained the vermiform appendix. Claudius Amyand,[1] in 1736, succesfully removed an acutely inflamed perforated appendix from a hernial sac in a boy, aged 11, in St. George's Hospital. This was apparently the first successful appendicectomy.

The appendix in the sac of a hernia is believed more likely to become acutely inflamed than is one within the abdomen. In the former location, it can become adherent in the sac as a result of mild inflammation or trauma. It is, of course, more easily exposed to trauma, and its blood supply is probably poorer than if it were within the abdomen. Because of the smallness of the internal ring and limited space of the hernial sac, inflammation within the hernia commonly causes gangrene and perforation.

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Acute appendicitis before the age of 1 year is uncommon; within the first 3 weeks of life, it is a rarity. The youngest patient in Gross' 2,070 cases of appendicitis at the Children's Medical Center in Boston[5] was 6 months of age. Snyder[11] reviewed the world literature up to 1951 in children younger than 2 years of age. He discovered 34 cases in patients less than 1 year old, and only 10 cases within the first 3 weeks of life.

Theories accounting for the infrequency of appendicitis in the newborn infant are: (1) the fetal type of appendix is, more or less, funnel shaped and is, therefore, less subject to obstruction; (2) diet consists of milk and soft food in the newborn period; and (3) there is a relatively low incidence of respiratory and intestinal infections among the newborn. The mortality rate reported in the literature is 29 per cent and the rate of perforation, peritonitis, or

abscess formation nearly 71 per cent, usually because of delay in diagnosis. Factors responsible for higher morbidity and mortality are as follows: the appendix is relatively large compared to the rest of the gastrointestinal tract, the organ is thin walled with meager blood supply, and the omentum is small and relatively undeveloped.

In a child with known inguinal hernia, symptoms of appendicitis are obscured by the fact that tenderness and localization of pain, as well as vomiting and prostration, could be caused by the hernia. Therefore, the diagnosis of strangulated hernia is made almost invariably if the patient is seen soon after acute onset. Later findings, of course, might suggest an abscess when the skin becomes hot, discolored, and fluctuant. Gross,[5] Swenson,[12] and others advocate a trial of taxis in early incarceration in children; if this is successful, operation is delayed 2 to 3 days to allow swelling and edema to subside.

In the following case an acute perforated and gangrenous vermiform appendix was found in a hernial sac in a premature infant who at time of operation weighed less than 6 pounds.

Case Report

W. W. S., Jr., premature white male, was born to a 33 year old primipara by breech delivery with use of cyclopropane oxygen anesthesia after episiotomy, on November 6, 1959. Estimated date of delivery had been January 17, 1960. The baby breathed spontaneously, and weighed 2 pounds, 14 ounces.

Physical examination showed no abnormalities. The baby's early course was uncomplicated, and feedings were given progressively by gavage. Nine days after birth an infection of the upper part of the respiratory tract developed and a throat culture showed hemolytic Staphylococcus aureus coagulase positive. The child was removed to the isolation nursery, where appropriate antibiotics were given. As the respiratory infection was gradually controlled, the baby became more vigorous, and was able finally to tolerate oral feedings. On December 14, 1959, he was circumcised. Four days later when he was dismissed, he weighed 5 pounds. A formula and vitamins were prescribed. During hospitalization an umbilical hernia with defect of 1 cm. had been noted.

The baby did well until 5 or 6 days before readmission when the mother noted a right inguinal hernia. On January 3 he became distended and vomited, and was returned to the hospital. At that time the abdomen was tympanitic and quiet, with a large, incarcerated, right inguinal hernia. The umbilical hernia was easily reduced. Temperature was 100.4 F. rectally. Laboratory data were as follows: white blood cell count 4,300/cu. mm., with 28 per cent segmented cells and 72 per cent lymphocytes; hemoglobin 10.45 Gm.; and hematocrit 36 per cent. A flat plate of the abdomen showed moderate gaseous distention of the stomach and small and large intestines, and soft tissue swelling in the right side of the scrotum.

After readmission a nasogastric tube was inserted and attached to Wangensteen suction apparatus. Gentle attempts to reduce the inguinal hernia by taxis were unsuccessful. Surgical consultation was obtained. Operation was advised; diagnosis was incarcerated, right inguinal hernia with possible strangulation.

Operation.—A vein in an ankle was exposed and incised, and a polyethylene catheter inserted, through which an electrolyte solution was given. A transverse incision in the right lower abdominal crease was extended down to the external oblique aponeurosis, which was opened in line with its fibers through the external ring. A large hernia was present through the internal ring, and consisted primarily of the cecum.

While the cecum was being freed, a large, vermiform appendix was observed to lie medially in the inguinal canal. It was gangrenous and covered with purulent exudate. In the proximal one-third was a large perforation from which poured purulent material. The base was no larger in diameter than a kitchen match-stick. Apparently it had been compressed by the internal ring and hernia sac, allowing for stasis and obstruction.

The appendix was removed, after the mesentery was clamped, and the stump was closed with a fine silk, purse string suture. The cecum was reduced into the abdomen, and the defect at the internal ring closed with progressive purse string sutures of catgut. Hernia repair was not attempted. A small Penrose drain placed in the inguinal canal was left in the medial portion of the incision, which was closed loosely with plain catgut except for the skin which was closed by interrupted sutures of 4.0 silk. The baby withstood the entire procedure well, and was returned to an incubator in good condition.

Pathologic Study.—Profuse serosanguinous and purulent inflammatory reaction which involved the entire wall of the appendix had destroyed the mucosa. Final pathologic diagnosis was "acute suppurative appendicitis with rupture."

Progress.—A nasogastric tube was attached to suction apparatus, and intravenous administration of the electrolyte solution was continued. Combined penicillin, streptomycin, and Chloromycetin therapy was parenterally administered, and small doses of cortisone were given intramuscularly. On the night of operation the temperature spiked to 104.4 F., but the next day it dropped precipitously to normal. The evening of the first postoperative day the child had 2 small, formed, yellow stools; the next morning he had 3 more stools and was expelling gas freely. The Levin tube was removed and glucose water was given orally, with gradual increase to formula. From that point the child had a rapid and uneventful convalescence, taking nourishment eagerly and retaining it. He remained afebrile. The antibiotics and cortisone were discontinued on the sixth postoperative day. Drain and sutures were removed the fifth postoperative day and the incision was noted to be healing per primum, with no evidence of infection. The patient was dismissed 9 days after operation. When last seen January 25, 1960, he weighed 7 pounds, 8 ounces, and appeared vigorous and happy. There was no evidence of recurrence of hernia.

Comment

Acute appendicitis in the neonatal period is extremely rare. When the condition is combined with incarcerated hernia, diagnosis is almost always obscured by findings relative to the rupture. The rapid recovery and smooth convalescence of this patient is perhaps accounted for, to some extent, by the fact that the appendix ruptured into the inguinal

canal; thus, overwhelming peritonitis was avoided because the internal ring had been plugged by the cecum. The cause of the acute appendicitis and perforation seems clear. There was mechanical obstruction at the base of the appendix, and doubtlessly interference with the blood supply in the mesoappendix. The cecum, however, was viable and was in no way compromised by the incarceration.

One might conjecture what the prognosis would have been if taxis of the incarcerated hernia had been successful and if the perforated appendix had been reduced into the abdomen. No doubt it would have been catastrophic, probably lethal.

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♦ Dr. Marcum, 811 Main Street, Big Spring.

Children's Accidents Decrease In Fall, Says Safety Council

The rate of serious accidents for children decreases when they enter elementary school and rises sharply after they leave, the National Safety Council reports.

Injuries sideline about one out of three boys and girls each year. Children are less injury-prone during the school year than they are during the summer months, according to the Health Insurance Institute.

More than 17,000 children and teenagers die as the result of accidents each year in this country. National Health Survey data show that in a year's time there are 336 injuries for each 1,000 children between the ages of 5 and 14.

Statistics marking summer as an injury-prone time seem largely influenced by the injuries of girls rather than boys. One-third of all activity-restricting injuries involving females occur during the summer; males experience about one-fourth of their total of restricted activity days in this quarter of the year. The highest accident rates occur among the young, especially males.

INJURY REPORT

The following table shows the number of injuries per 1,000 persons per year by age:

Age	No. of Injuries Per 1,000 Persons Per Year
0-4	300
5-14	336
15-24	327
25-44	294
45-64	246
65+	234

Source: United States National Health Survey.

★ Coming Meetings

Texas Medical Association, Austin, Sept. 17-18, 1960, Jan. 28, 1961; Galveston, April 23-25, 1961. Dr. May Owen, Fort Worth, Pres.; Mr. C. Lincoln Williston, 1801 North Lamar Blvd., Austin, Exec. Secy.

American Medical Association, Washington, D. C., Nov. 28-Dec. 1, 1960. Dr. E. Vincent Askey, Los Angeles, Pres.; Dr. F. J. L. Blasingame, 535 North Dearborn, Chicago 10, Exec. Vice-Pres.

Current Meetings

AUGUST

American Congress of Physical Medicine and Rehabilitation, Washington, D.C., Aug. 21-26, 1960. Dr. F. J. Kottke, Minneapolis, Pres.; Dorothea C. Augustin, 30 N. Michigan Ave., Chicago 2, Executive Secy.

American Hospital Association, San Francisco, Aug. 29-Sept. 1, 1960. Dr. Russell A. Nelson, Baltimore, Md., Pres.; Dr. Edwin L. Crosby, 18 E. Division Street, Chicago, Executive Director.

SEPTEMBER

American Association of Obstetricians and Gynecologists, Hot Springs, Va., Sept. 8-10, 1960. Dr. Robert A. Ross, Chapel Hill, N. C., Pres.; Dr. Clyde L. Randall, 216 Summer St., Buffalo 22, Secy.

American College of Radiology, Atlantic City, Sept. 30-Oct. 1, 1960. Dr. Earl E. Barth, Chicago, Pres.; Mr. W. C. Stronach, 20 N. Wacker Dr., Chicago 6, Executive Director.

American Society of Clinical Pathologists, Chicago, Sept. 24-Oct. 2, 1960. Dr. John J. Clemmer, Albany, Pres.; Mr. Claude E. Wells, 445 Lake Shore Drive, Chicago 11, Executive Secy.

Association of American Physicians and Surgeons, St. Louis, Sept. 29-Oct. 1, 1960. Dr. Louis Wegryn, Elizabeth, N. J., Pres.; Mr. Harry E. Northam, 185 N. Wabash Ave., Chicago 1, Executive Director.

Tri-State Medical Assembly, Louisiana, Sept. 14-15, 1960. Dr. R. B. Langford, Shreveport, Pres.; Dr. J. W. Wilson, Jr., 940 Margaret Place, Shreveport, Secy.

Texas Heart Association, Dallas, Sept. 9-10, 1960. Dr. Robert E. Leslie, El Campo, Pres.; Mr. Ernest T. Guy, 404 Jesse H. Jones Library Building, Houston 25, Executive Director.

Texas Pediatric Society, Sept. 30-Oct. 1, 1960, Dallas. Dr. Byron York, Houston, Pres.; Dr. C. E. Gilmore, 811 Bonham, Paris, Secy.

Tenth District Society, September, 1960. Dr. J. W. McCall, Jr., Beaumont, Pres.; Dr. Irving M. Richman, 3280 Fannin St., Beaumont, Secy.

National and Regional

American Academy of Allergy, Washington, D. C., Feb. 6-8, 1961. Dr. Bram Rose, Montreal, Canada, Pres.; Dr. Joseph Noah, 100 N. Euclid Ave., St. Louis 8, Mo., Secy.

American Academy of General Practice, Miami, April 17-20, 1961. Dr. John G. Walsh, Sacramento, Calif., Pres.; Mr. Mac F. Cahal, Volker Blvd. at Brookside, Kansas City 12, Executive Secy.

American Academy of Pediatrics. Dr. William W. Belford, San Diego, Calif., Pres.; Dr. E. H. Christopherson, 1801 Hinman Ave., Evanston, Ill., Executive Director.

American Association for Thoracic Surgery. Dr. William E. Adams, Chicago, Pres.; Dr. Hiram T. Langston, 7730 Corondelet Ave., St. Louis 5, Secy.

American Association of Genito-Urinary Surgeons. Dr. Reed M. Nesbitt, Ann Arbor, Mich., Pres.; Dr. W. J. Engel, 2020 E. 93rd St., Cleveland 6, Secy.

American Association of Plastic Surgeons. Dr. Lyndon A. Peer, New Jersey, Pres.; Dr. Thomas D. Cronin, 6615 Travis St., Houston 25, Secy.

American College of Allergists, Dallas, March 12-17, 1961. Dr. Giles A. Koelsche, Rochester, Minn., Pres.; Mr. Eloi Bauers, 2160 Rand Tower, Minneapolis, Executive Vice-Pres.

American Academy of Dermatology and Syphilology, Chicago, Dec. 3-8, 1960. Dr. Francis W. Lynch, St. Paul, Minn., Pres.; Dr. Robert R. Kierland, Mayo Clinic, Rochester, Minn., Secy.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 9-14, 1960. Dr. John H. Dunnington, New York, Pres.; Dr. W. L. Benedict, 15 Second St. S.W., Rochester, Minn., Secy.

American Association for Maternal and Infant Health. Dr. M. Edward Davis, Chicago, Pres.; Mrs. Patricia Dorr, 116 S. Michigan Ave., Chicago 3, Executive Director.

American Cancer Society, New York, Oct. 26-27, 1960. Dr. Warren H. Cole, Chicago, Pres.; Mr. Granville Whittlesey, 521 West 57th St., New York 19, Secy.

American College of Chest Physicians. Dr. Seymour M. Farber, San Francisco, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut, Chicago 11, Executive Director.

American College of Gastroenterology, Philadelphia, Oct. 23-29, 1960. Dr. Joseph Shaiken, Milwaukee, Pres.; Mr. Daniel Weiss, 33 West 60th, New York 23, Executive Director.

American College of Obstetricians and Gynecologists. Dr. John I. Brewer, Chicago, Pres.; Mr. Donald F. Richardson, P. O. Box 749, Chicago 90, Executive Secy.

American College of Physicians. Dr. Howard P. Lewis, Portland, Ore., Pres.; Mr. E. R. Loveland, 4200 Pine, Philadelphia 4, Secy.

American College of Surgeons, San Francisco, Oct. 10-14, 1960. Dr. Owen H. Wangensteen, Minneapolis, Pres.; Dr. William E. Adams, 950 E. 59th St., Chicago, Secy.

American Dermatological Association. Dr. Marion B. Sulzberger, New York, Pres.; Dr. Wiley M. Sams, 308 Ingraham Bldg., Miami 32, Secy.

American Gastroenterological Association. Dr. H. Marvin Pollard, Ann Arbor, Pres.; Dr. Wade Volwiler, University of Washington School of Medicine, Seattle 5, Secy.

American Gynecological Society. Dr. Karl H. Martzloff, Portland, Pres.; Dr. A. A. Marchetti, 3800 Reservoir Rd. N.W., Washington 7, D.C., Secy.

American Heart Association, St. Louis, Oct. 21-25, 1961. Dr. A. Carlton Ernstene, Cleveland, Pres.; Mr. William F. McGlone, 44 E. 23rd, New York 10, Secy.

American Laryngological, Rhinological, and Otological Society, Lake Placid Club, May 23-25, 1960. Dr. Fletcher D. Woodward, Charlottesville, Va., Pres.; Dr. C. S. Nash, 708 Medical Arts Bldg., Rochester, N. Y., Secy.

American Neurological Association. Dr. Derek Denny-Brown, Boston, Pres.; Dr. Melvin D. Yahr, New York Neurological Institute, 710 W. 168th Street, New York 32, Secy.

American Ophthalmological Society. Dr. A. B. Reese, New York, Pres.; Dr. M. C. Wheeler, 30 W. 59th, New York 19, Secy.

American Orthopaedic Association. Dr. John Royal Moore, Philadelphia, Pres.; Dr. Lee Ramsay Straub, 535 East 70th St., New York 21, Secy.

American Pediatric Society. Dr. Samuel Z. Levine, New York, Pres.; Dr. A. C. McGuinness, Room 1036, 2800 Quebec St., N.W., Washington 8, D.C., Secy.

American Proctologic Society. Dr. H. R. Reichman, Salt Lake City, Pres.; Dr. Norman D. Nigro, 10 Peterboro, Detroit 1, Secy.

American Psychiatric Association. Dr. William Malamud, New York, Pres.; Dr. C. H. Hardin Branch, 156 Westminister Ave., Salt Lake City, Secy.

American Public Health Association, San Francisco, Oct. 31-Nov. 4, 1960. Dr. Malcolm H. Merrill, Berkeley, Calif., Pres.; Dr. Berwyn F. Mattison, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, New York, Oct. 2-7, 1960. Dr. J. Earl Remlinger, Jr., Wilmette, Ill., Pres.; Dr. Robert L. Patterson, 612 Bershire Drive, Pittsburgh 15, Secy.

American Surgical Association, White Sulphur Springs, W. Va., April 3-6, 1960. Dr. Warren H. Cole, Chicago, Pres.; Dr. William Altemeier, Cincinnati General Hospital, Cincinnati 29, Secy.

American Urological Association. Dr. William M. Coppridge, Durham, N. C., Pres.; Mr. William P. Didusch, 1120 N. Charles St., Baltimore 1, Executive Secy.

International College of Surgeons, U. S. Chapter. Dr. Henry Meyerding, Rochester, Minn., Pres.; Dr. Ross T. McIntire, 1516 Lake Shore Dr., Chicago, Executive Director.

National Tuberculosis Association. Dr. H. McLeod Riggins, New York, Pres.; Mrs. Wallace B. White, 651 Marlborough Rd., Brooklyn, Secy.

Radiological Society of North America, Cincinnati, Ohio, Dec. 4-9, 1960. Dr. Lawrence L. Robbins, Boston, Pres.; Dr. Donald S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

South Central Association of Blood Banks. Dr. John B. Alsever, Phoenix, Pres.; L. Ruth Guy, Ph.D., Room 1101, Stoneleigh Hotel, Dallas, Secy.

Southern Medical Association, St. Louis, Oct. 31-Nov. 3, 1960. Dr. Edwin H. Lawson, New Orleans, Pres.; Mr. Robert F. Butts, 2601 Highland Ave., Birmingham 5, Ala., Executive Secy.

Southern Psychiatric Association, Virginia Beach, Va., Oct. 2-4, 1960. Dr. David A. Wilson, Charlottesville, Va., Pres.; Dr. Richard Proctor, Winston-Salem, N. C., Secy.

Southern Surgical Association, Boca Raton, Fla., Dec. 6-8, 1960. Dr. Francis Massie, Pres.; Dr. John D. Martin, Jr., Emory University, Ga., Secy.

Southwest Allergy Forum. Dr. Johnny A. Blue, Oklahoma City, Pres.; Dr. George L. Winn, Suite 104, Lister Medical Building, 430 Northwest Twelfth St., Oklahoma City, Secy.

Southwest Regional Cancer Conference, Fort Worth, Oct. 23, 1960. Dr. Robb Rutledge, Fort Worth, Chm.; Mrs. Ira Frances Ball, Westchester House, Fort Worth, Secy.

Southwestern Medical Association, El Paso, Oct. 20-22, 1960. Dr. R. L. Deter, El Paso, Pres.; Dr. Merle Thomas, 1501 Arizona Building, El Paso, Secy.

Southwestern Society of Nuclear Medicine, San Antonio. Dr. Peter E. Russo, Oklahoma City, Pres.; Dr. J. R. Maxfield, Jr., 2711 Oak Lawn Avenue, Dallas, Secy.

Southwestern Surgical Congress, Fort Smith, Ark. Dr. Fred H. Krock, Fort Smith, Ark., Pres.; Mary O'Leary, 813 Medical Arts Bldg., Oklahoma City, Exec. Secy.

United States-Mexico Border Public Health Association. Mr. Frank J. Von Zuben, Jr., Austin, Pres.; Dr. Jorge Román, 243 United States Court House, El Paso, Secy.

State

Private Clinics and Hospitals, Dallas, December, 1960. Dr. Vance Terrell, Stephenville, Pres.; Mr. B. J. Warren, Deaton Hospital, Galena Park, Secy.

Texas Academy of General Practice, Dallas, Oct. 3-5, 1960. Dr. E. Sinks McLarty, Galveston, Pres.; Mr. Donald C. Jackson, 1905 N. Lamar, Austin, Executive Secy.

Texas Academy of Internal Medicine. Dr. Merton M. Minter, San Antonio, Pres.; Dr. Hugo T. Engelhardt, 1216 Main, Houston, Secy. Meetings restricted to members.

Texas Air-Medics Association, Galveston, April 22-25, 1961. Dr. C. D. Henry, San Antonio, Pres.; Dr. C. F. Miller, Box 1338, Waco, Secy.

Texas Association for Mental Health, Galveston, 1961. Mr. William R. Ransone, Dallas, Pres.; Mrs. Lawrence Marcus, 3525 Arrowhead Drive, Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, Feb. 10-11, 1961. Dr. Oran V. Prejean, Dallas, Pres.; Dr. Hugh W. Savage, 815 Fifth Ave., Fort Worth, Secy.

Texas Association of Public Health Physicians, Galveston, April 22-25, 1961. Dr. L. P. Walter, Austin, Pres.; Dr. W. V. Bradshaw, Jr., 1800 University Drive, Fort Worth, Secy.

Texas Club of Internists. Dr. W. W. Bondurant, Jr., San Antonio, Pres.; Dr. T. Haynes Harvill, Medical Arts Building, Dallas 1, Secy.

Texas Chapter, American Academy of Pediatrics, Galveston, April 22-25, 1961. Dr. J. T. Bennett, El Paso, Pres.; Dr. W. W. Kelton, Jr., 108 West 30th, Austin, Secy.

Texas Chapter, American College of Chest Physicians, Galveston, April 22-25, 1961. Dr. Hiram M. Anderson, San Angelo, Pres.; Dr. Milton V. Davis, 3707 Gaston Avenue, Dallas, Secy.-Treas.

Texas Dermatological Society, Galveston, April 22-25, 1961. Dr. M. W. Harrison, Houston, Pres.; Dr. D. Shelton Blair, 1609 Medical Arts Building, Dallas, Secy.-Treas.

Texas Diabetes Association, Galveston, April 22-25, 1961. Dr. James A. Greene, Houston, Pres.; Dr. John W. Chriss, 2436 Morgan Street, Corpus Christi, Secy.-Treas.

Texas Division, American Cancer Society. Dr. David A. Todd, San Antonio, Pres.; Mr. Curt W. Reimann, 5014 Bull Creek Rd., Austin 3, Executive Director.

Texas Hospital Association. Mr. F. S. Walters, Jr., Amarillo, Pres.; Mr. O. Ray Hurst, 1905 N. Lamar, Austin, Executive Director.

Texas Industrial Medical Association, Galveston, April 22-25, 1961. Dr. Noble B. Daniel, Texarkana, Pres.; Dr. J. G. Burdick, Pasadena, Secy.

Texas Neuropsychiatric Association, Galveston, April 22-25, 1961. Dr. Clarence S. Hoekstra, Dallas, Pres.; Dr. E. Ivan Bruce, Jr., Galveston, Secy.-Treas.

Texas Ophthalmological Association, Galveston, April 22-25, 1961. Dr. Otto Lippmann, Austin, Pres.; Dr. James H. Scruggs, Waco, Secy.

Texas Orthopedic Association, Galveston, April 22-25, 1961. Dr. Ike S. McReynolds, Houston, Pres.; Dr. Margaret Watkins, Dallas, Secy.-Treas.

Texas Otolaryngological Association, Galveston, April 22-25, 1961. Dr. August J. Streit, Amarillo, Pres.; Dr. Louis E. Adin, Jr., Dallas, Secy.

Texas Physical Medicine and Rehabilitation Society, Galveston, April 22-25, 1961. Dr. Edward M. Krusen, Dallas, Pres.; Dr. Oscar Selke, Medical Professional Building, Houston, Secy.

Texas Proctologic Society, Houston, February, 1961. Dr. J. Wade Harris, Houston, Pres.; Dr. H. Gray Carter, 915 St. Joseph St., Dallas, Secy.

Texas Public Health Association, Fort Worth, March 5-8, 1961. Mrs. Maggie Belle Davis, Corpus Christi, Pres.; Mr. Joseph N. Murphy, Jr., Box 4012, Austin 51, Executive Secy.

Texas Radiological Society, Fort Worth, Jan. 20-21, 1961. Dr. Delphin von Briesen, El Paso, Pres.; Dr. R. P. O'Bannon, 1216 Pennsylvania, Fort Worth, Secy.

Texas Rheumatism Association, Dallas, Dec. 9, 1960. Dr. Howard C. Coggeshall, Dallas, Pres.; Dr. J. Morris Horn, 3707 Gaston, Dallas, Secy.

Texas Society of Anesthesiologists, Galveston, April 22-25, 1961. Dr. Randle J. Brady, Houston, Pres.; Dr. Eugene L. Slataper, Houston, Secy.

Texas Society of Athletic Team Physicians, Galveston, April 22-25, 1961. Dr. W. S. Horn, Jr., Fort Worth, Pres.; Dr. Louis Levy, Fort Worth, Secy.-Treas.

Texas Society of Gastroenterologists and Proctologists, Galveston, April 22-25, 1961. Dr. H. Gray Carter, Dallas, Pres.; Dr. A. C. Broders, Jr., Temple, Secy.-Treas.

Texas Society of Pathologists, Inc., Galveston, April 22-25, 1961. Dr. O. J. Wollenman, Jr., Fort Worth, Pres.; Dr. Vernie A. Stembridge, Dallas, Secy.-Treas.

Texas Society of Plastic Surgeons, Galveston, April 22-25, 1961. Dr. J. B. Patterson, Fort Worth, Pres.; Dr. Raymond O. Brauer, Houston, Secy.-Treas.

Texas Society on Aging, Houston, Oct. 6-8, 1960. Dr. Ernest W. Keil, Temple, Pres.; Mrs. William B. Ruggles, 3701 Stratford, Dallas, Secy.-Treas.

Texas State Board of Medical Examiners, Fort Worth, Dec. 1-3, 1960. Dr. M. H. Crabb, Fort Worth, Secy.; Mrs. Carolyn H. Millard, 1714 Medical Arts Bldg., Fort Worth, Assistant Secy.

Texas Surgical Society, San Antonio, Oct. 3-4, 1960. Dr. Robert Wilson Crosthwait, Waco, Pres.; Dr. G. V. Brindley, Jr., Scott and White Clinic, Temple, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 2-3, 1960. Dr. Lyle J. Logue, Houston, Pres.; Dr. Oliver Suehs, 14 Medical Arts Square, Austin, Secy.

Texas Traumatic Surgical Society, Galveston, April 22-25, 1961. Dr. Edward R. Rowe, Galveston, Pres.; Dr. John C. Long, Plainview, Secy.-Treas.

Texas Tuberculosis Association, Corpus Christi, March 16-18, 1961. Dr. J. Edward Johnson, Pres.; Miss Pansy Nichols, P. O. Box 6158, Austin 21, Executive Director.

Texas Urological Society, Wichita Falls, January 21-22, 1961. Dr. Joseph Mitchell, Dallas, Pres.; Dr. O. C. Berg, 1300 8th St., Wichita Falls, Secy.

District

First District Society. Dr. Russell Holt, El Paso, Pres.; Dr. Gordon L. Black, 1501 Arizona St., El Paso, Secy.

Second District Society, Snyder, 1961. Dr. M. J. Loring, Midland, Pres.; W. S. Parks, Jr., 2009 W. Wall, Midland, Secy.

Third District Society, Lubbock. Dr. Grady M. Wallace, Lubbock, Pres.; Dr. H. Fred Johnson, 2308 W. Eighth, Amarillo, Secy.

Fourth District Society. Dr. S. Braswell Locker, Brownwood, Pres.; Dr. J. G. Bodenhamer, Mason, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 8-9, 1961. Dr. John W. Chriss, Pres.; Dr. James Gabbard, 1001 Louisiana, Corpus Christi, Secy.

Seventh District Society. Dr. Robert N. Snider, Austin, Pres.; Dr. Richard Lucas, 502 W. 13th, Austin, Secy.

Eighth District Society, Corpus Christi. Dr. M. Warren Hardwick, Angleton, Pres.; Dr. J. L. Coleman, Box 3346, Victoria, Secy.

Ninth District Society, Bellville, Spring, 1961. Dr. Irving M. Watson, Jr., Conroe; Dr. William E. Sharp, 721 E. Texas, Baytown, Secy.

Eleventh District Society. Dr. Marlin T. Braswell, Henderson, Pres.; Dr. Floyd Verheyden, 813 John St., Jacksonville, Secy.

Twelfth District Society, Waco, January 10, 1961. Dr. Bernard Rosen, Corsicana, Pres.; Dr. R. L. Campbell, 205 S. 15th St., Corsicana, Secy.

Thirteenth District Society, Fort Worth, Fall, 1960. Dr. William B. Allensworth, Mineral Wells, Pres.; Dr. R. D. Moreton, 1217 W. Cannon, Fort Worth, Secy.

Fifteenth District Society. Dr. Charles Wise, Naples, Pres.; Dr. George Bennett, 402 S. Bolivar, Marshall, Secy.

Clinics

Blackford Memorial Cancer Lectures, Denison, Nov. 11, 1960. Dr. Andrew Jackson, Denison, Chm.

Dallas Southern Clinical Society Conference, Dallas, March 20-22, 1961. Dr. Frank H. Kidd, Jr., Dallas, Pres.; Millard J. Heath, 433 Medical Arts Bldg., Dallas 1, Executive Officer.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 23-25, 1961. Dr. Max E. Johnson, San Antonio, Pres.; S. E. Cockrell, 202 W. French Place, San Antonio, Exec. Secy.
New Orleans Graduate Medical Assembly, New Orleans, March 6-9, 1961. Dr. Maurice E. St. Martin, New Orleans, Pres.; Mrs. Irma B. Sherwood, 430 Tulane Ave., New Orleans 12, Executive Secy.
North Texas-Southern Oklahoma Fall Clinical Conference. Dr. Frank J. Lee, 1300 8th, Wichita Falls, Chm.
Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 24-26, 1960. Dr. Vernon D. Cushing, Oklahoma City, Pres.; Miss Alma F. O'Donnell, 503 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, Houston. Dr. C. Alsworth Calhoun, Houston, Pres.; Mrs. W. H. Dahme, 412 Jesse H. Jones Library Bldg., Houston 25, Exec. Secy.

Board Examinations

Texas State Board of Examiners in Basic Sciences, Austin, Houston, Galveston and Dallas. Henry B. Hardt, Ph.D., Fort Worth, Pres.; Mrs. Betty J. Anderson, Chief Clerk, State Office Bldg., 201 E. 14th St., Austin.

MEDICOLEGAL NOTES

Texas Tuberculosis Code A Physician's Responsibility

In 1959, the Texas Legislature passed a new law, the Texas Tuberculosis Code, representing more than a year's work on the part of numerous physicians and members of the Texas Tuberculosis Association and Texas Medical Association's Committee on Tuberculosis. Those who cooperated believed that the state's antiquated laws concerning persons afflicted with tuberculosis seriously hampered efforts to eliminate tuberculosis in Texas or to afford patients with tuberculosis the care, treatment, and hospitalization needed.

The Code places cooperative responsibilities and duties upon individuals and governmental agencies dealing with and caring for patients with tuberculosis. As a result of the new code, which became effective August 11, 1959, the following duties and responsibilities were placed upon the Texas physician, whether he is engaged in private practice or whether, in addition to his private practice, he also serves as local health officer:

1. Any physician who diagnoses or treats a patient with tuberculosis must report the case as soon as possible to the local health officer. Such report may be in writing or by telephone and should include: name, address, age, sex, color, and occupation of patient; date of onset of disease; probable source of infection.

2. The local health officer is required to keep a record of all cases reported, with other information the Texas State Department of Health requires. In addition, he must make a monthly report to the State Department of Health of all cases reported.

3. Immediately after notification of any case of tuberculosis, the local health officer is required to send to the attending physician, or with the attending physician's permission, directly to the patient information relative to control and prevention of the disease.

4. Every physician who examines or treats a person with tuberculosis must instruct him in measures to prevent spread of the disease and must impress upon him the necessity of treatment until he is cured.

5. The attending physician has the authority and responsibility to place the patient under the following restrictions:

a. "Special isolation."—The patient is prohibited from attending places of public assembly, or from sleeping with others or using the same towels and napkins. He must be provided separate eating utensils.

b. "Partial disinfection."—Disinfection of discharges or excretions of the patient and disinfection of his clothing and any room occupied during his illness are required.

6. When a case of tuberculosis is reported, the local health officer is authorized to notify the patient to place himself under the care of a physician licensed by the Texas State Board of Medical Examiners for treatment until the local health officer receives a certificate that the patient is free from tuberculosis in an infectious or contagious state. This certificate must state that the person examined has been given an actual and thorough examination; the test or tests used shall be those approved by the Texas State Department of Health. The certificate must also contain a report of the test.

7. Physicians and local health officers are prohibited from issuing certificates of freedom from tuberculosis unless the tests provided for have been given and the person is free from tuberculosis in an infectious or contagious state. A physician, before issuing a certificate of freedom from tuberculosis, must submit to the local health officer a report showing that the required tests have been made. The tests must be made by either the physician or a laboratory approved by the State Department of Health.

8. If an attending physician knows or has good reason to suspect that a person with tuberculosis is conducting himself, or is about to conduct himself, in a manner to expose others to infection, he is required to notify the local health officer of the essential facts of the case, along with the name and address of the patient. The health officer shall then investigate the case and employ measures required by the Code as to isolation and disinfection.

9. In cases in which a person with tuberculosis fails or refuses to carry out the directions of the local health officer or his physician or in cases in which the latter official is of the opinion that treatment at home cannot be effected with reasonable safety to the public, he can require an examination. If the subject has tuberculosis in an infectious and contagious state, the local health officer must quarantine the patient until he is no longer infectious. If quarantine facilities are not available within the health officer's jurisdiction, the patient may be sent to a State Tuberculosis Hospital designated by the Board for Texas State Hospitals and Special Schools.

10. If the patient is not cured upon release from quarantine, the local health officer must inform the patient what further treatment is required.

The Texas Tuberculosis Code clearly states the responsibilities of Texas physicians. Failure to observe requirements in the Code subjects the violator to prosecution for a misdemeanor. Conviction entails punishment of a fine of not less than $50 nor more than $500 and/or imprisonment up to 30 days. Although this criminal aspect of the Code discourages tuberculous individuals from disregarding directions of local health officers and attending physicians, *it is equally applicable in a case in which a physician fails to comply with his responsibilities and duties required by the Code.*

—PHILIP R. OVERTON, LL.B., Austin.

American Medical Writers Schedule Chicago Meeting

Hotel Morrison, Chicago, will be headquarters building for the seventeenth annual meeting of the American Medical Writers' Association, set for September 30 to October 1.

Presiding for the meeting will be Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association and former editor of the *Journal of the American Medical Association.*

Papers on phases of medical writing will be presented on September 30, climaxed with a fellowship hour sponsored by the Schering Corporation, and a banquet. Awards in medical journalism, fellowships in the association, awards to medical periodicals for distinguished service in journalism, and the winning essay for nonmedical writing, will be presented.

On October 1, a Conference on Medical Communications will be held, with Dr. Walter Kahoe, director of the medical department of J. B. Lippincott Company, presiding. Dr. W. D. Snively, Jr., medical director of Mead Johnson Company, arranged the program.

Speakers include Dr. Arthur H. Wells, editor of *Minnesota Medicine;* Selma De Bakey of the Ochsner Medical Foundation; Dr. Richard M. Hewitt, emeritus professor of the University of Minnesota; Dr. Morris Fishbein, former editor of the *Journal of the American Medical Association;* Dr. Joseph Garland, editor of the *New England Journal of Medicine;* and Dr. Laurance D. Redway, editor of the *New York Journal of Medicine.*

Congress on Nutrition to Meet In United States for First Time

The fifth International Congress on Nutrition will meet September 1-7, 1960, in Washington, D. C. This will be the first time the organization has met in the United States. An all-day symposium on "World Food Needs and Food Resources" will be a main feature of the scientific program. The Congress is arranged under the auspices of the International Union of Nutritional Sciences of the National Academy of Sciences—National Research Council.

Simultaneous translation into English, Spanish, French and German will be provided at scientific sessions. Approximately 2,500 nutritionists representing almost every country in the world will participate in the Congress. For further information, those interested may write to Mr. Sidney S. Negus, Medical College of Virginia, Richmond.

American Rhinologic Society Schedules Meeting in Chicago

Physicians are invited to attend the sixth annual meeting of the American Rhinologic Society, October 8, in Chicago. There is no registration fee.

Among the special guests will be Dr. Henry L. Williams of Mayo Clinic, Rochester, Minn., and Dr. Morris Fishbein, Chicago.

Two symposia will be presented on "Nasal Pressure Tests" and "Choanal Atresia." Other subjects on the program will be "Implant Materials—Compatabilities—Antigenicities," "Review of Reports on Lyophilized Bone and Cartilage," "The Comparative Anatomy of the Nose," "Hormones in Rhinology," and "Anti-Inflammatory Agents —Basic Concepts."

A 2 day surgical seminar in the Illinois Masonic Hospital, Chicago, will immediately precede the meeting.

For further information, those interested may write Dr. Robert M. Hansen, American Rhinologic Society, 1735 North Wheeler Avenue, Portland 17, Ore.

Rehabilitation Institute Scheduled

An Institute on Rehabilitation will be held at the Texas Medical Association headquarters building in Austin on September 22 and 23. Other sponsors besides the Association are the Texas Hospital Association, Texas Society of Physical Medicine and Rehabilitation, and Texas Occupational Therapy Association.

The Institute is designed for superintendents, clinical directors, hospital administrators, and physicians who treat patients with pulmonary tuberculosis, psychiatric disorders, and other conditions that require long term treatment. The need for comprehensive rehabilitation programs for such patients and the most effective use of ancillary personnel will be discussed by Col. Albert J. Glass, M.C., Washington, D.C., Chief Psychiatry and Neurology Consultant, Headquarters, Department of the Army; Dr. George W. Brooks, Vermont State Hospital, Waterbury, Vt.; and Miss Wilma West, O.T.R., New York, editor of "Changing Concepts and Practices in Psychiatric Occupational Therapy."

There is no registration fee for the course. Further information may be obtained from the Executive Secretary, Texas Medical Association, 1801 North Lamar Boulevard, Austin.

DeBakey to Speak Before Interstate Postgraduate Group

The Interstate Postgraduate Medical Association will hold its forty-fifth Scientific Assembly in Pittsburgh, October 31-November 3. The program provides category I credit for American Association of General Practitioner members.

Dr. Michael E. DeBakey, Houston, will participate in the program. His presentations will include "Cerebro-Vascular Insufficiency," and "The Clinical Significance of Atherosclerotic Occlusive Disease."

Registration fee is $10. Registration blanks and hotel accommodation request forms may be obtained from the Interstate Postgraduate Medical Association, Box 1109, Madison 1, Wis.

Cardiac Conference in Denver

The ninth Western Cardiac Conference will be held August 15-20 in Denver.

The following subjects will be discussed: intracardiac shunts, cardiac failure, radiology, cardiac surgery, vascular surgery, vascular disease, hypertension, electrocardiography, atherosclerosis, and space medicine. Dr. Lawrence Lamb of San Antonio will participate on the program.

For further information, those interested may write to the Colorado Heart Association, 1636 Logan Street, Denver 3.

Tri-State Medical Assembly To Meet in Shreveport, September 14

The Tri-State Medical Assembly, made-up of physician members from Arkansas, Louisiana, and Texas, will meet in Shreveport, La., September 14, 1960.

The program will consist of a series of talks in the morning, and workshops on obstetrics, surgery, pediatrics, and medicine in the afternoon. Case material for the workshops will be presented by the services from the Confederate Memorial Medical Center.

A dinner will be held during the evening, with the speaker being Dr. Edmond Souchan, New Orleans. Dr. Souchan, who is past president and a founding member of the New Orleans Jazz Club, will give an illustrated talk on "The Story of New Orleans Jazz."

Among the other guest speakers will be Dr. Charles W. Crumpton, Madison, Wis.; Dr. Donald W. Mulder, Rochester, Minn.; Dr. Arnold J. Kremen, Minneapolis; Dr. George H. Schade, San Francisco; and Dr. Joseph B. Sheffery, Washington, D. C.

For registration blanks and further information, physicians may write to Dr. J. W. Wilson, 940 Margaret Place, Shreveport.

Public Health Association To Convene in New York

The eighty-eighth annual meeting of the American Public Health Association, will be held in New York, October 31-November 4.

Expected to attend are 5,000 men and women who plan and direct programs of official and voluntary health agencies on national, state, and local levels in all parts of the Americas and abroad.

Major sessions will include an opening symposium on man and his changing environment and a closing symposium on present status and future directions of work in malignant diseases. Scientific sections represent dental health, engineering and sanitation, epidemiology, food and nutrition, health officers, laboratory, maternal and child health, medical care, mental health, occupational health, public health education, public health, nursing school health, and statistics.

Registration is open to nonmembers. For further information, physicians may write Dr. Berwyn F. Mattison, 1790 Broadway, New York 19.

Biomedical Electronic Program Set

The thirteenth annual conference on Electrical Techniques in Medicine and Biology, scheduled for October 31-November 2 in Washington, D. C., will feature a diversified program on biomedical electronics, with emphasis on analytical techniques.

The meeting will be sponsored by the Joint Executive Committee in Medicine and Biology, representing the Institute of Radio Engineers, American Institute of Electrical Engineers, and Instrument Society of America.

Further information may be obtained by writing Mr. Lewis Winner, 152 West Forty-second Street, New York 36.

Conference on Space Medicine To Be Held October 24-26

A 3 day international symposium on the "Medical and Biological Aspects of Energies of Space" will be held October 24-26 in San Antonio. It is sponsored by the Air Force School of Aviation Medicine, Aerospace Medical Center, Brooks Air Force Base.

The meeting will be divided into three day-long segments: delineation of the energies of space important from medical and biological standpoints; application of these energies for biological and medical purposes; and medical and biological protection against those energies of space for which protection is required.

Applications for invitations may be secured from Jack Harmon, Symposium Coordinator, Southwest Research Institute, Box 2296, San Antonio 6.

International Congress of Physical Medicine

The third International Congress of Physical Medicine will be held in Washington, D. C., from August 21 to August 26.

It is the objective of the congress to further the development of knowledge and professional and technical skills through the exchange of information concerning the advances made in the field of physical medicine and rehabilitation. Papers will be presented by experts in all fields of medicine and surgery together with other aspects of rehabilitation—social, educational, and vocational. Delegates from 30 countries are expected.

Further information may be obtained from the third International Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2.

Ophthalmological Conference in Asia

The first Congress of the Asia-Pacific Academy of Ophthalmology will be held in Manila from October 10-13, under the sponsorship of the Philippine Ophthalmological Society. The main theme of the conference, with delegates from the Asia-Pacific regions and guests from the Americas and Europe, will be "Blinding Diseases of the Asia-Pacific Regions."

There will be guest lectures by prominent ophthalmologists from America, Australia, Europe, and India. For registration forms or further information, those interested may write Dr. Jesus V. Tamesis, 42 Quezon Boulevard, Quezon City, Philippines.

Obstetricians and Gynecologists to Meet

The Central Association of Obstetricians and Gynecologists will hold its annual meeting in Kansas City, Mo., October 6-8.

Scientific programs will be held during the mornings, with a special scientific program by the Kansas City Gynecological Society. All members of organized medicine, as well as interns and residents, are invited to attend the sessions. There is no fee for registration. Further information may be obtained from Dr. Herman L. Gardner, Central Association of Obstetricians and Gynecologists, 6436 Fannin Street, Houston 25.

Female Genital System Cancer Subject of Houston Conference

The fifth annual Clinical Conference on Cancer of the Uterine Cervix, Endometrium, and Ovary will be held at the University of Texas M. D. Anderson Hospital and Tumor Institute, Houston, October 21-22, 1960.

Among the topics to be discussed will be "Carcinoma of the Cervix and Pregnancy," "Experience with Pelvic Lymphadenectomy," "Technique and Evaluation of Preoperative Radium Therapy," "Difficulties in Histologic Diagnosis," "Radiotherapy: Cobalt-60 Strip Technique," "The Use of Radioactive Colloidal Gold," "Value of Urological Studies," "Microscopic Grading and Radiosensitivity."

Dr. Hans-Ludwig Kottmeier of the Karolinska Sjukhuset Radiumhemmet in Stockholm, Sweden, will be guest speaker at the conference. Another featured out-of-state speaker will be Dr. James W. Reagan, Institute of Pathology, Western Reserve University, Cleveland. The program is under the direction of Dr. Felix N. Rutledge, Section of Gynecology, Department of Surgery at M. D. Anderson in Houston.

Those desiring further information may contact the University of Texas M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston 25.

Military Surgeons to Convene

The Military Role in Medical Progress will be the theme of the sixty-seventh annual convention of the Association of Military Surgeons of the United States, to be held October 31-November 2 in Washington, D. C.

Those interested in further information may write to the Association of Military Surgeons, Mayflower Hotel, Washington, D. C.

EDUCATION

Experimental Research Program In Second Year at Galveston

Underway for the second year at the University of Texas Medical Branch, Galveston, is an experimental research training program, sponsored by the National Institute of Health, an agency of the United States Public Health Service.

Because of the decline of interest among the nation's young medical students in basic research sciences and medical education, Congress granted funds to be used for a period of 5 years for research training.

Students who qualify are granted a 3 months summer fellowship for training under the guidance of a faculty member in one of the basic sciences. After preliminary training, the basic science student may work under the supervision of a member of the clinical faculty.

If the student wishes to work on a master's or doctor of philosophy degree, as well as studying for the degree doctor of medicine, the program will pay graduate school tuition and for graduate record examinations.

The 18 students working in the program this summer attend selected lectures on research techniques and problems three times a week. The study includes historical characters and personalities of medicine.

Mental Health Clinic Study

The Board for Texas State Hospitals and Special Schools will probably have to ask the Legislature for more than 41 million dollars per year to operate its 18 institutions in 1962-1963, Raymond Vowell, executive director of the hospital system, has recently indicated. This figure calls for no general increase.

The board was also reminded that there should be an agreement between the Texas State Department of Health and itself as to which agency should be responsible for the operation of mental health clinics. It authorized its staff members to supply information to a Texas Medical Association committee studying such clinics, and instructed Mr. Vowell and Dr. C. J. Ruilmann of the board to confer with Dr. H. C. Mitchell, Waco; Dr. Dorothy Wyvell, Midland; and Dr. A. D. Pattillo, Austin, on mental health clinics.

Out-patient clinics at the state tuberculosis hospitals were authorized by the board after Dr. Daniel E. Jenkins of Baylor University College of Medicine and member of the Texas Medical Association Committee on Tuberculosis, pointed out that intensive care is necessary to make sure that patients discharged from state hospitals do not have a recurrence requiring rehospitalization.

Chest Physicians Award Fellowship Certificates to 15

Receiving fellowship certificates in the American College of Chest Physicians during the 1960 annual meeting in June were 15 Texas physicians.

They were Dr. James K. Alexander, Houston; Dr. William J. Block, San Antonio; Dr. Aubrey L. Bradford, United States Army Dispensary, Fort Bliss; Dr. John J. Bunting, Houston; Dr. Edward Egbert, El Paso; Dr. Leroy J. Kleinsasser, Dallas; Dr. Lawrence E. Lamb, San Antonio; Dr. Robert E. Leslie, El Campo; Dr. Ben F. Mitchel, Dallas; Dr. George C. Morris, Jr., Houston; Dr. D. W. Quick, Jr., Beaumont; Dr. Thomas M. Runge, Austin; Dr. Melvin L. Samuels, Houston; and Dr. Francis W. Wilson, Port Arthur.

The University of Texas Medical Branch

Dr. Wiktor W. Nowinski, director of the Tissue Metabolism Laboratory at the University of Texas Medical Branch, has accepted an invitation from the New York Academy of Science to organize an international symposium in New York next spring.

Dr. Nowinski recently returned from a 7 months' visit to Paris at the invitation of the College de France. He lectured as visiting professor on "Problems of Metabolism on Cellular Growth." While in Paris, he worked on the isolation of substances and their effects on various growing cells in the embryo.

Dr. Charles E. Hall, professor in the Department of Physiology, and *Dr. Edward G. Rennels,* associate professor in anatomy at the medical branch, presented papers at the first International Congress of Endocrinology at Copenhagen, Denmark, in July.

Texas Doctors Awarded Fellowships in Pediatrics

Two Texas doctors have been awarded Wyeth Laboratories residency fellowships in pediatrics, Dr. Philip S. Barba, past president of the American Academy of Pediatrics, has announced.

They are Dr. Kenneth M. Wiggins of Irving, who will take his residency at Children's Medical Center, Dallas; and Dr. William P. Robert, Jr., of Beaumont, who will study at the Baylor University College of Medicine Affiliated Hospitals, Houston.

The two are among 20 from 16 different states given the fellowships, and are the third group to benefit from the grants established in 1958.

Postgraduate Cruise to West Indies

A Postgraduate Medical Seminar Cruise to the West Indies will be sponsored by the Duke University Medical School from November 9-18. The new Kungsholm, Sweden's largest transatlantic liner and cruise ship, will sail from New York City to the Virgin Islands and San Juan, Puerto Rico.

Shipboard lectures on various subjects in internal medicine, pediatrics, and surgery will be given by the members of the faculty of Duke University Medical School. The instructional program will provide 24 hours credit toward postgraduate requirements of the American Academy of General Practice. While designed primarily for the general practitioner, the program should be of interest and value to the specialist. Informal panel discussions, clinicopathological conferences, and formal presentations will be given by members of the faculty.

For further information, physicians may write to the Allen Travel Service, Inc., 565 Fifth Avenue, New York 17, N. Y.

Postgraduate Courses

Laryngology and Bronchoesophagology, Chicago, October 17-29.—The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in laryngology and bronchoesophagology from October 17 through October 29 in Chicago. Registration will be limited to 15 physicians who will receive instruction by means of animal demonstrations, practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, and didactic lectures. Interested registrants may write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

Pediatric Oncology, Houston, November 11-12.—A Clinical Symposium on Pediatric Oncology will be presented in Houston, November 11-12. It will be sponsored by the Universtity of Texas Postgraduate School of Medicine and the University of Texas M. D. Anderson Hospital and Tumor Institute in Houston. The program will include lectures by guest speakers and by members of the M. D. Anderson staff, as well as case presentations and panel discussions. Important aspects of chemotherapy, surgery, and radiotherapy in the management of children with various types of neoplastic disease will be covered. For further information, physicians interested may write to the Office of the Dean, The University of Texas Postgraduate School of Medicine, 410 Jesse Jones Library Building, Texas Medical Center, Houston 25.

Nursing Fellowships Offered

The National League for Nursing announces continuation of the National League for Nursing Fellowship Program which is made possible by a grant from the Commonwealth Fund.

The amount of the annual award, which may range from $3,000 to $5,000 or more in exceptional situations, will be determined by individual circumstances. Fellowships are awarded for full time study and on a master's or post-master's degree and extend overtime in accordance with approved programs of study.

Requirements for eligibility are that the applicant is free to pursue a full-time program of master's or post-master's degree study; be accepted by a recognized university; and be a United States citizen.

Application forms for fellowships may be obtained from the National League for Nursing, Inc., 10 Columbus Circle, New York 19. Completed applications, including transcripts from educational institutions attended, should be filed before January 15, 1961, for grants to be awarded for study beginning summer or fall, 1961.

OF GENERAL INTEREST

Personals

Dr. and Mrs. E. Trowbridge Wolf, left for Europe July 1 where they will attend the fourth International Goiter Conference in London, the first International Congress of Endocrinology in Copenhagen, a Symposium on Fluid and Electrolytes at Vienna under the auspices of the American Medical Association, and the sixth International Congress of Internal Medicine in Basel, Switzerland.

Dr. Milford O. Rouse of Dallas addressed the Society of Professional Business Consultants during their sessions in Chattanooga on May 16.

Dr. May Owen of Fort Worth was nominated recently for the Private Practitioners of Pathology Foundation's Award for outstanding service. The award will be presented at the Foundation's meeting in September.

Dr. Bolton Boone, Dallas, was selected by *The Oak Cliff Tribune,* Dallas newspaper, as Man of the Month for May.

Dr. James R. Maxfield, Dallas, and *Dr. Mavis P. Kelsey,* Houston, participated in the seventh annual meeting of the Society of Nuclear Medicine, held in Estes Park, Colo., recently.

Dr. James A. Knight took over the duties of assistant dean of Baylor University College of Medicine in Houston July 1.

Dr. John M. Knox, Houston, was elected recently to the Board of Directors of the Society for Investigative Dermatology.

Dr. Lloyd Southwick, Edinburg, was named chairman-elect of the American Academy of General Practice State Editors' Group when the academy met recently in Philadelphia.

Illinois Physicians Fight Educational Indifference

Physicians of Quincy, Ill., who are members of the Adams County Medical Society, have taken arms against problems of educational indifference; and they intend to persist in their efforts until the public is awakened.

But the "public" isn't their only concern; their own profession also perturbs them. Too few of their own and too few other citizen groups are taking action to meet the challenge at the local level.

United with the Swanberg Medical Foundation and other civic organizations, the county society has encouraged academic achievement within its own community, and has heartily attempted to make the public aware that such achievement is a national resource and should not be wasted.

Establishment of the Quincy Major Learning Program in 1956 dedicated to a college education for every talented high school graduate of Quincy and Adams County, marked the beginning. Expanded gradually over the years, the program now includes cash and certificate awards to top students of local high school graduating classes.

The society sponsors a nonprofit educational program, the Society for Academic Achievement, which grants university loans, scholarships, and fellowships to deserving students and promotes high school honorary societies for the top 10 per cent of graduating classes.

It gives financial grants to local high school teachers to attend guidance counseling workshops at nearby universities, and it arranges publication and distribution of literature on scholarship opportunities.

Recently the society submitted a resolution to the Illinois State Medical Society recommending that "component societies be encouraged to carry on similar educational programs in their respective communities." It was approved by the House of Delegates at the May, 1960, annual meeting.

In addition to this, the county has attempted to stimulate public interest and discussion on education by sponsoring public lectures.

Several other groups have initiated the Society for Academic Achievement in their local schools. Among them are: Christian County (Ill.) Medical Society and the Christian County Bar Association and Kiwanis and Rotary Clubs in Arizona, Minnesota, New Jersey, and Wisconsin. Plans are being made to start the program in New York and Nebraska.

Pediatric Newspaper Originated in July

The first news publication devoted exclusively to pediatrics, *Pediatric Herald,* was originated in July. Issued monthly by Editorial Projects, Inc., a firm specializing in medical and scientific publications, it will be sponsored by 3 firms: Wyeth Laboratories, Gerber Products Company, and Pfizer Laboratories.

The newspaper will be distributed free to the nation's 10,000 pediatricians and to approximately 70,000 general practitioners responsible for a large proportion of medical care given the country's 57,000,000 children.

Pediatric Herald will provide comprehensive coverage of developments in the preservation of health, treatment of disease during childhood and adolescence, and growth and development of children in the intellectual, emotional, and social spheres.

Nuclear-Age Hospital Underway in San Antonio

A fortress against "natural and man-made disasters, as well as diseases," the proposed Southwest Texas Methodist Hospital in San Antonio, is under construction.

Groundbreaking ceremonies last May 25 initiated the nuclear age institution. When completed it will include advance electronic facilities and a futuristic "survival complex."

The first stage of the four-stage construction project in northwest San Antonio will provide 175 short-term beds for the acutely ill, with all vital services below ground in radiation-proof areas. It is expected to be in operation within 2 years.

One feature of the new hospital will be the communication facilities which will serve as a Civil Defense Communication Center in times of major man-made or natural disasters. Also included will be a closed circuit television to permit children to see and be seen by their hospitalized parents and relatives during visiting hours.

Other electronic features include devices which will record the patient's physiological condition without waking him at night and which will allow hot meals any hour of the day or night, by means of microwave cooking facilities.

The hospital, dedicated to "Serving Man to Honor God" is located on Louis Pasteur Drive, between Fredericksburg and Babcock Roads.

Medical Research Spending Increase Due to Government

National spending on medical research, which will reach a record $715,000,000 this year, is about 8 times higher than in 1947, according to the July issue of *Patterns of Disease,* a Parke, Davis & Company publication.

Chiefly responsible for the sharp rise in funds for medical research is the Federal Government, which has increased contributions from $28,000,000 in 1947 to $305,000,000 in 1959, according to the pharmaceutical publication. Once a relatively modest supporter of medical research, the Government now gives more money than all other sources combined.

Support from other sources also has climbed. Last year, the pharmaceutical industry spent $190,000,000 on research and development—50 per cent more than in 1957. Of the total spent in 1959, $174,700,000 was for research and development within the companies and $15,300,000 for research outside the companies. In addition, the pharmaceutical industry allocated $5,950,000 in 1959 for unrestricted gifts and grants to schools and hospitals and $2,000,000 for contributions to organizations, such as the National Fund for Medical Education, which supports medical and related schools.

Chart for Aphasia Patients

A "Hand Talking Chart," 20 signs that became a universal one hand manual language to improve clinical aid, is available free for aphasia patients so that they can impart their basic needs.

The chart is provided by the International Research Council, an organization which has as its purpose dissemination of knowledge about aphasia associated with hemiplegia. Those desiring a copy may write Dr. Hamilton Cameron, 601 West 110th Street, New York City, the originator of the chart.

How the Aged Pay Studied in Vermont

A significant study showing how older people pay their doctor bills has been made by Vermont State Medical Society's Committee on Aging.

The reason for the study was (1) Vermont has a higher percentage of its population over 65 than any other state, and (2) with all the interest shown in health care for the aged, the Vermont society thought a survey of the way older people pay their bills might be in order. The study covered 5,172 persons ranging from 65 to 106 years of age. The median was 74. Two women to every one man sought physician care in this age group. Participating were 188 practitioners.

The findings are as follows:

Eighty-seven per cent planned to pay the physician's fee through Blue Shield-Blue Cross, private insurance, from savings, or with current income.

The patients' families planned to assume the responsibility in 12 per cent of the cases. The responsibility fell to the city or town in only 5 per cent of the cases.

Physicians subsidized in full 2.3 per cent of the patient care reported, and gave reduced charges to 12 per cent.

It was found that 66 per cent lived with spouse or relatives, 20 per cent lived alone.

Twenty per cent of the group studied were still working, 71 per cent were retired.

Fifty per cent were on social security, 16 per cent were on Old Age Assistance, and 13 per cent had other retirement plans.

Blue Cross-Blue Shield is helping to meet the costs of medical care by covering 40 per cent of those surveyed. Another 12 per cent had private health insurance, making a total of 52 per cent with some prepaid plan.

Galveston Psychopathic Hospital Cuts Indigent Patients for Year

For approximately 1 year while major renovations are underway at the Galveston State Psychopathic Hospital, the hospital cannot accept any indigent patients.

Private patients will be cared for through temporary facilities of the Faculty House at the University of Texas Medical Branch, Galveston, some sections of the R. Waverly Smith Pavilion, and the Randall Pavilion.

Renovation of the hospital is the second phase of the rebuilding program of psychiatric hospital facilities, and is a part of the broader expansion and modernization program at Galveston. The first phase was the conversion of the former Negro hospital into the now completed Randall Pavilion.

Southern Medical Association History To Be Distributed to Physicians

A complete history of the 54 year old Southern Medical Association was published August 15. It was written by C. P. Loranz, Birmingham, advisor and professional relations counselor for the organization.

The publication will be distributed to members as soon as possible, as well as to other physicians. The history details the association's growth from its beginning in 1906, and includes statistical data on officers, places of meeting, research awards, and membership figures. It contains numerous photographs.

Insurance Company to Build Nursing Home Facilities

An educational facility for administrators of nursing homes will be constructed by Mutual of Omaha insurance company in Washington, D. C.

The research center will be a model 50-bed nursing home with lecture and classrooms and an auditorium. In addition, it may be headquarters for the American Nursing Home Association.

The grant was announced by Dr. Charles W. Mayo, chairman of the awards and research committee, who said that "judicious use" of the nursing homes could reduce the cost problems of health care for the aged, since many aged persons need time to recover from major illnesses, but do not need the extensive facilities of a hospital. He said that low cost nursing home care would provide an answer to the cost problem.

Insurance Premiums Rate Adjustment Necessary

Re-evaluation of the Texas Medical Association's Group Accidental Death Insurance Program has shown that the original premium charged—90 cents per $1,000—was too low in view of the fact that the loss experience at the end of a 2 year period was 218 per cent. The Charles O. Finley & Company, which offers this type of insurance coverage, is, therefore, announcing an increase in the rate of $1.35 per $1,000.

In addition to accidental death benefits, the insurance plan includes provision for payment of the full principal sum for loss of a hand, foot, or eye.

Federal Aviation Agency Reinstates Exam Rule

The Federal Aviation Agency now requires that student and private pilots be given medical examinations by designated medical examiners, according to Dr. James L. Goddard, Civil Air Surgeon. This rule reinstates a practice which was in effect from 1926 until 1945.

Any physician may be considered eligible for designation as an examiner. Those doctors in localities where flying activities are conducted may file an application for designation by writing to the Civil Air Surgeon, Federal Aviation Agency, Washington 25, D. C. There are at present some 400,000 active civil airmen of whom approximately 240,000 are examined each year.

New Federal Insurance Plans

The first two of about 40 plans available to Federal employees under the Federal Employees Health Benefits Act of 1959 went into effect in July. The announcement was made by the United States Civil Service Commission, Washington 25, D.C.

The two plans are (1) the government wide indemnity plan with Aetna Life Insurance Company and (2) the government wide service benefit plan with Blue Cross-Blue Shield.

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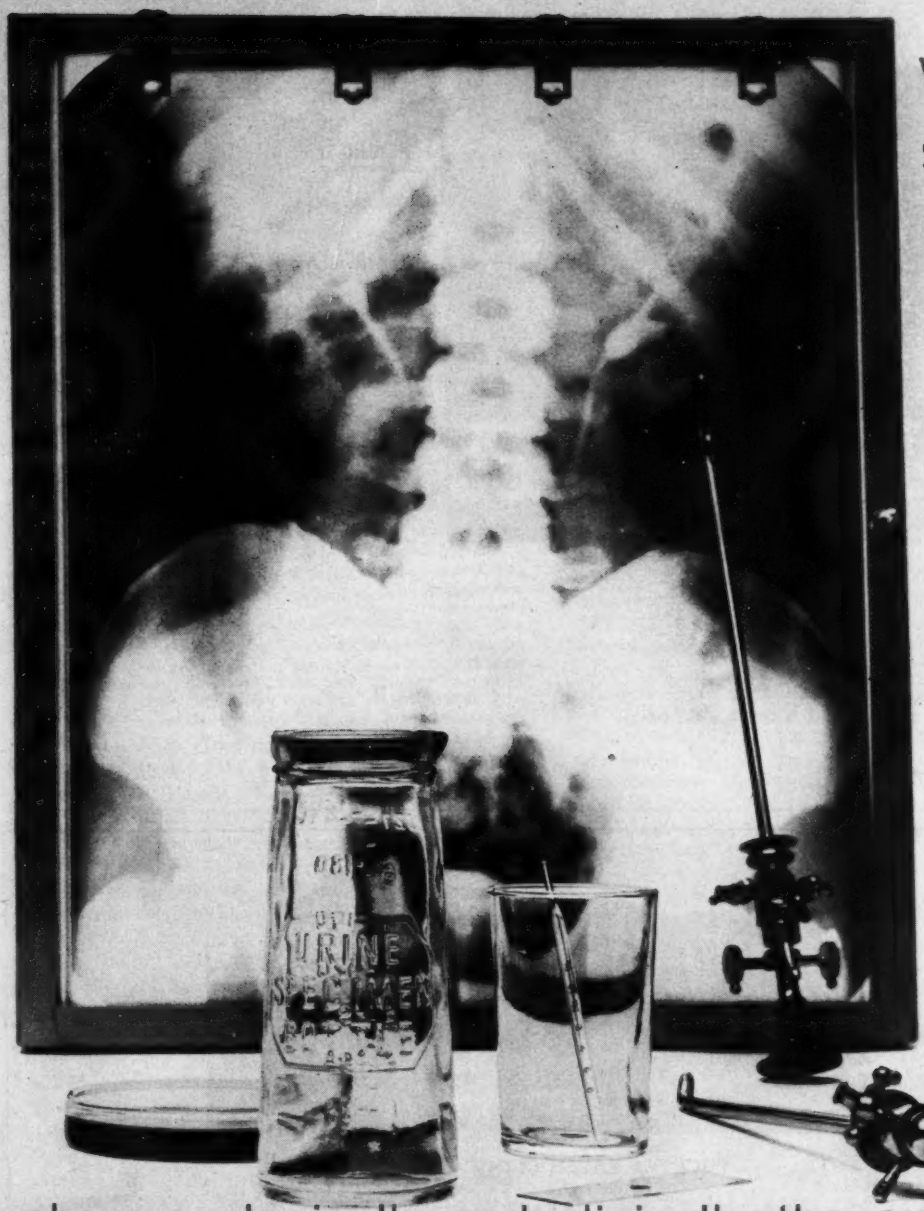

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Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

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Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

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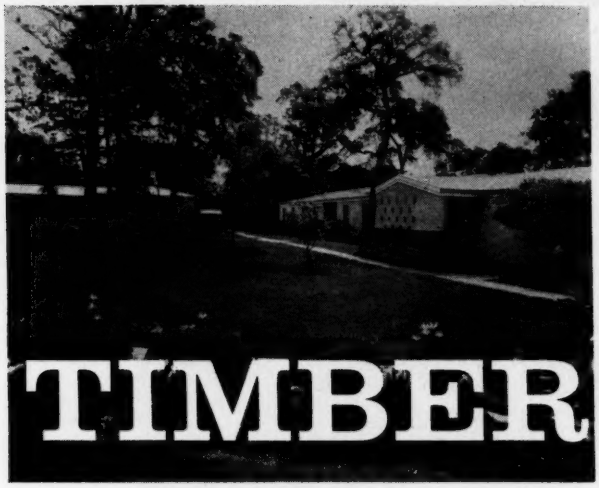

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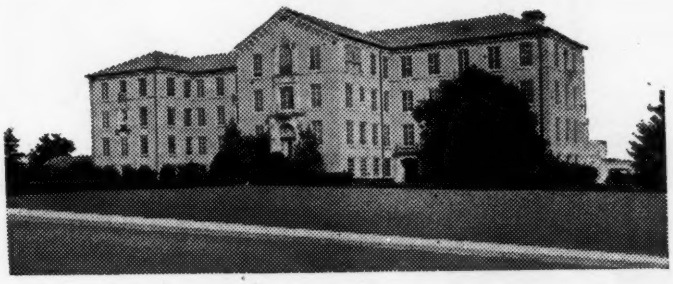

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Readings on Diabetes Mellitus

Diabetes mellitus has been recognized since the second century when Aretaeus the Cappadocian, a Greek physician, gave the first accurate account of the disease and gave it its present name. The article is in his Extant Works, and is entitled, "On diabetes."

In a survey conducted in 1958, the Public Health Service, Department of Health, Education, and Welfare estimated that there are 2,990,000 cases of diabetes in the United States. Of that number, 1,400,000 are unsuspected. The National Health Survey, a household-interview type of survey which has been conducted since July, 1957, will help to determine the prevalence of known diabetes.

The following are selected items on diabetes mellitus which are available on loan from the Memorial Library of the Texas Medical Association in Austin:

Andresen, J., and Lauritzen, E.: Blood Groups and Diabetes Mellitus, Diabetes 9:20-24 (Jan.-Feb.) 1960.

Appelman, D. H.: Diabetic Detection, Am. Pract. and Digest Treat. 10:1499-1500 (Sept.) 1959.

Aring, C. D.: Diabetic Neuritis (Neuropathy), A.M.A. Arch. Neurol. & Psychiat. 2:211-212 (Feb.) 1960.

Boshell, B. R.: Hypoglycemia Agents for Oral Administration, New England J. Med. 262:297-298 (Feb. 11) 1960; 262:80-81 (Jan. 14) 1960.

Brandaleone, H.: Employability of the Diabetic, Ann. New York Acad. Sc. 82:256-265 (Sept. 25) 1959.

Clarke, D. W., and Forbath, N.: Studies on the Mode of Action of DBI, Metabolism 8:553-556 (July) 1959.

Cohen, A. S.; Vance, V. K.; Runyan, J. W., Jr.; and Hurwitz, D.: Diabetic Acidosis; An Evaluation of the Cause, Course and Therapy of 73 Cases, Ann. Int. Med. 52:55-86 (Jan.) 1960.

Current Trends in Research and Clinical Management of Diabetes, Ann. New York Acad. Sc., vol. 32, art. 2:191-644 (Sept. 29) 1959.

Dekaban, A., and Baird, R.: The Outcome of Pregnancy in Diabetic Women, 1. Fetal Wastage, Mortality, and Morbidity in the Offspring of Diabetic and Normal Control Mothers, 2. Analysis of Clinical Abnormalities and Pathologic Lesions in Offspring of Diabetic Mothers, J. Pediat. 55:563-576 (Nov.) 1959; 55:767-776 (Dec.) 1959.

Diabetes—A Continuing Health Program, J. Maine M. A. 50:408-409 (Nov.) 1959.

Ellenberg, M.: Diabetic Neuropathy Following Stress Situations, Am. J. M. Sc. 238:418-426 (Oct.) 1959.

Entmacher, P. S.: Acceptability of Diabetics for Life Insurance, Ann. New York Acad. Sc. 82:251-257 (Sept. 25) 1959.

Kelly, P. J.: Current Practices in General Medicine Management of Complications Seen in the Lower Extremities of Diabetic Patients, Proc. Staff Meet. Mayo Clin. 34:511-518 (Oct. 29) 1959.

Knowles, H. C., Jr.: Management of the Adolescent Diabetic Patient, Postgrad. Med. 26:766-772 (Dec.) 1959.

Leevy, C. M.; Tornow, Abraham; Greenberg, Philip; and Zinke, Myra: Mode of Action and Clinical Effects of Chlorpropamide in Diabetes Mellitus, Ann. New York Acad. Sc. 74:725-737 (March 30) 1959.

Marble, Alexander: Oral Hypoglycemic Agents in the Management of Diabetes, M. Clin. North America 42:1163-1177 (Sept.) 1958.

Moss, J. M., and DeLawter, Dewitt: Metahexamide in Diabetes Therapy, Ann. New York Acad. Sc. 82:614-617 (Sept. 25) 1959.

Mulholland, H. B.; Owen, J. A.; and Taylor, J. B.: Complications of Diabetes Mellitus, DM (June) 1960.

Oakley, W.: Advances in the Treatment of Diabetes Mellitus, Practitioner 183:478-482 (Oct.) 1959.

Perdue, G. W.; Engelhardt, H. T.; and Coronado, Marguerite: Diets to Control Diabetes Mellitus, Texas J. Med. 55:283-286 (April) 1959.

Pomeranze, J.: Subthreshold Diabetes, Ann. Int. Med. 51:219-226 (Aug.) 1959.

Pomeranze, Julius; Mouratoff, G. T.; Raymond, J. G.; and King, E. J.: Phenethylbiguanide, A New Orally Given Hypoglycemic, J.A.M.A. 171:252-258 (Sept. 19) 1959.

Ralli, E. P.: Nutritional Disturbances Associated with Diabetes Mellitus, Postgrad. Med. 26:612-616 (Nov.) 1959.

Remein, Q. R.: A Current Estimate of the Prevalence of Diabetes Mellitus in the United States, Ann. New York Acad. Sc. 82:229-235 (Sept. 25) 1959.

Sindoni, A. M., Jr.: The Role of the Physician in Diabetes Mellitus: Oral Medication vs. Insulin, Delaware M. J. 31:348-353 (Nov.) 1959.

Steinberg, A. G.: The Genetics of Diabetes: A Review, Ann. New York Acad. Sc. 82:197-207 (Sept. 28) 1959.

Van Eck, W. F.: The Effect of a Low Fat Diet on the Serum Lipids in Diabetes and its Significance in Diabetic Retinopathy, Am. J. Med. 27:196-211 (Aug.) 1959.

Wilkerson, H. L.: Maternal Prediabetes and Outcome of Pregnancy; A Preliminary Report, Am. J. Pub. Health 49:1032-1040 (Aug.) 1959.

Wilkerson, H. L.: Pregnancy and the Prediabetic State, Ann. New York Acad. Sc. 82:219-228 (Sept. 25) 1959.

Williams, R. H.; Pollen, R. H.; Tanner, D. C.; and Barnes, R. H.: Oral Antidiabetic Therapy, Ann. Int. Med. 51:1121-1133 (Dec.) 1959.

Williams, R. H., and Steiner, D. F.: Symposium on the Hypoglycemic Agents Mechanism of Phenethylbiguanide, Metabolism 8:548-552 (July) 1959.

Gifts to the Library

Dr. Albert L. Exline, Austin, 36 journals.

Dr. Joe T. Gilbert, Austin, 6 journals.

Dr. Henry L. Hilgartner, Austin, 21 journals, 1 pamphlet.

Dr. Georgia F. Legett, Austin, 131 journals, 12 pamphlets, and 1 reprint.

Dr. Albert D. Pattillo, Austin, 62 journals.

Dr. Morris Polsky, Austin, 62 journals.

Dr. Clift Price, Austin, 325 journals.

Dr. David R. Womack, Austin, 62 journals, 29 pamphlets.

★ Books

Books Newly Acquired

American Druggist Blue Book, 1960-1961, Chicago, American Druggist, 1960.

Armstrong, J. R.: *Lumbar Disc Lesions,* ed. 2, Edinburgh, E. & S. Livingstone, 1958.

Beaumont, William: *Experiments and Observations of the Gastric Juice and the Physiology of Digestion,* Facsimile of the original edition of 1833, New York, Dover Publications, 1959.

Brock, Samuel: *Injuries of the Brain and Spinal Cord,* ed. 4, New York, Springer, 1960.

Burke, Richard M.: *An Historical Chronology of Tuberculosis,* Springfield, Charles C Thomas, 1955.

Camac, C. N. B.: *Classics of Medicine and Surgery,* first published in 1908 as epoch-making contributions to medicine surgery and the allied sciences, New York, Dover Publications, 1959.

Clark, Marguerite: *Medicine Today,* New York, Funk and Wagnalls, 1960.

Clendening, Logan: *Source Book of Medical History,* New York, Dover Publications, 1942.

Elkinton, J. Russell, and Danowski, T. S.: *The Body Fluids,* Baltimore, Williams and Wilkins, 1955.

Frederick, Portia M., and Towner, Carol: *The Office Assistant in Medical or Dental Practice,* ed. 2, Philadelphia, W. B. Saunders, 1960.

Ginzberg, Eli, Ed.: *The Nation's Children,* New York, Columbia Univerity Press, 1960, vols. 1 and 2.

Judovich, Bernard, and Bates, William: *Pain Syndromes, Diagnosis and Treatment,* ed. 4, Philadelphia, F. A. Davis, 1953.

Kevorkian, Jack: *Medical Research and the Death Penalty,* New York, Vantage Press, 1960.

Macgregor, Agnes R.: *Pathology of Infancy and Childhood,* Edinburgh, E. & S. Livingstone, 1960.

MacLeod, Douglas H., and Read, Charles D.: *Gynecology,* ed. 5, Boston, Little, Brown & Co., 1955.

Millman, Milton: *Pardon My Sneeze,* ed. 2, San Diego, Frye & Smith Ltd., 1950.

Mulholland, John Hugh: *Current Surgical Management,* ed. 2, Philadelphia, W. B. Saunders, 1960.

National Foundation: *Collected Reprints of the Grantees of the National Foundation,* vol. 20, pt. 1-2, New York, 1959.

Riseman, Joseph E. F.: *P - Q - R - S - T,* ed. 4, New York, Macmillan, 1960.

Rodahl, Kaare; Nicholson, Jesse T.; and Brown, Ernest M., editors: *Bone as a Tissue,* New York, McGraw-Hill, 1960.

Rogers, Fred B.: *Help-Bringers,* New York, Vantage Press, 1960.

Salvatori, Philip L.: *The Story of Contact Lenses,* New York, Obrig Laboratories, 1960.

Scobee, Richard G.: *Rehabilitation of a Child's Eyes,* revised, St. Louis, C. V. Mosby, 1955.

Sher, Elizabeth, and others: *List Method of Psychotherapy,* New York, Philosophical Library, 1960.

Stanton, Isabel Alice: *A Dictionary for Medical Secretaries,* Springfield, Ill., Charles C Thomas, 1960.

Turek, Samuel L.: *Orthopedics, Principles and their Application,* Philadelphia, J. B. Lippincott, 1959.

Williamson, Paul: *Office Procedures,* ed. 2, Philadelphia, W. B. Saunders, 1960.

Year Book Publishers: *Year Book of Endocrinology,* 1959-1960, Chicago, Year Book Publishers, 1960.

Year Book Publishers: *Year Book of Pathology and Clinical Pathology,* 1959-1960, Chicago, Year Book Publishers, 1960.

Book Notes

Long-Term Illness, Management of the Chronically Ill Patient

MICHAEL G. WOHL, M.D., F.A.C.P., Former Clinical Professor of Medicine (Endocrinology), Philadelphia General Hospital and Temple University School of Medicine; Chief of Nutrition Clinic, Philadelphia General Hospital; Consultant Physician in Medicine, Albert Einstein Medical Center; Attending Physician, Home for the Jewish Aged. With collaboration of 79 contributing authorities. 705 pages. $17. Philadelphia and London, W. B. Saunders Company, 1959.

Dr. Wohl presents a comprehensive survey of the management of the patient with prolonged illness. The term "long-term" is used since the author feels that chronic illness conveys a sense of hopelessness and implies a state of permanent disability.

The book is divided into two sections. The first deals with hospital and home care, rehabilitation, psychologic problems, and nursing procedures. These are particularly beneficial to the general practitioner and the young intern. The second section deals with the treatment of specific diseases. Many chapters include a discussion of up-to-date promising therapies undergoing clinical trials. The problem presented by the increasing numbers of long-term patients (2,000,000 in 1950 survey) in general hospitals must be studied in the light of the fact that such hospitals are constructed, staffed, and financed primarily for the care of short-term patients. The survey should aid the practicing physician and medical student in developing a proper attitude toward prolonged illness.

The book has an interesting prolegomenon by Chauncey D. Leake.

The Cigarette Habit: A Scientific Cure

ARTHUR KING. 95 pages. $2. Garden City, New York, Doubleday & Company, Inc., 1959.

Arthur King is the pseudonym of a writer, scholar, and scientist who is presently engaged in writing his dissertation at Columbia University. He presents a new system based on modern medical and psychological advances. His plan permits smokers to quit smoking comfortably, without gaining weight, and without jitters.

Physiologists, biochemists, and endocrinologists will be interested in the chapter entitled "Cigarettes, Cancer, and Statistical Concepts."

The Story of Dissection

JACK KEVORKIAN, M.D., 80 pages. $3.75. New York, Philosophical Library, 1959.

An enthralling account of the often weird and peculiar methods used in dissection of the animal and human body from antiquity to the days of Puritanism, together with the various taboos and superstitions connected with such enterprises.

★ American Medical Association

AMA Official Favors HR 12580 (Mills Bill)

This month brings to a climax action to obtain passage of legislation providing medical care for the aged. In contention is not whether such legislation should be passed, but the extent and nature of the coverage to be underwritten by federal tax funds and the administrative mechanism which is to be employed.

On June 27, Dr. Leonard Larson, President-Elect of the American Medical Association, appeared before the Senate Finance Committee to testify for HR 12580 (the Mills Bill) and to give the position of the American Medical Association in supporting the bill. Dr. Larsen's 19 page statement assembles into a comparatively brief summary objective facts on the health status and financial status of the 65 year old age group. He exposes the blanket allegation that the old people of the nation are "sick and debilitated" to a searching examination. Similar scrutiny is focused upon arguments of the proponents of Forand-type legislation that our 15,500,000 aged cannot afford to purchase medical care.

The statement is unfortunately too long to print in its entirety. In view of the emotional heat the legislative fight has engendered, however, a review of the key facts at this stage of the struggle will help to clarify our thinking, and will enable physicians to express their position more vigorously to friends and foe alike.

First, what is the health status of the aged?

Are older people of this nation in bad health? No absolute statistical information has been compiled, but a limited sampling by Dr. Ethel Shanas of the University of Chicago revealed "20 per cent or fewer of persons over 65 years were sick to the degree that illness limited their normal activity." Observation and experience makes this percentage acceptable to physicians. Chronic illness is found in greater degree among older people. Nevertheless, physicians know and the public should learn, that the term "chronic" must not be confused with "disability." Thus, it cannot be reasonably argued that a majority or a substantial minority of older people are sick and disabled. There is, in fact, evidence to warrant the conclusion that a substantial majority in this category are in good health.

Second, what is the financial status of the old people, and what is their capacity to pay for their medical and health care expenses? Again, no conclusive figures are available. The 15 per cent of the 15,500,000 aged who are on public welfare presumably are incapable of paying such expenses. Nevertheless, these indigent patients are eligible to receive medical care under federally aided public assistance programs. No unchallengeable and complete statistics on financial status of the remaining 85 per cent of the aged population have been compiled, but there are some important evidentiary facts.

1. Four million are employed or are married to employed individuals with incomes relatively the same as other similarly employed workers of younger ages.

2. Sixty per cent—9½ million—receive OASDI cash benefits. One and a half million receive cash benefits from private pension plans, and this number is steadily increasing.

3. One million persons over age 65 receive veterans' pensions, and the number is rapidly increasing. Another million receive railroad and civil service pensions, and still another million receive income from privately purchased annuities.

4. In 1957, median net worth of OASDI benefits recipients and wives who were recipients was $9,616. This figure is rising.

5. Seventy per cent of couples who receive OASDI benefits own their own homes, 85 per cent of which are mortgage free. In 1958, 3 of 4 persons over age 65 had liquid assets, and 40 per cent had liquid assets of more than $2,000. Also, this age group has lowest indebtedness and the smallest financial obligations.

Further, the economic status of older people in this country is improving, not declining, as reflected by the steady decrease of persons receiving Old Age Assistance, increased number of persons covered in private pension plans, growth of the purchase of voluntary health insurance, and increasing opportunities for experienced aged persons to continue in useful employment.

From the foregoing facts, one irrefutable conclusion can be drawn. Nowhere does there exist sufficient statistical information to establish accurately how many older people need medical and health care and how many are unable to pay for such care. Since these basic requirements for intelligent legislation are in dispute, a sincere wish to help the aged needy demands a careful survey of their needs, a step now being undertaken for the 1961 White House Conference on Aging. Any legislation should be withheld until sufficient accurate information becomes available. To do otherwise is a callous and cynical disregard of fact in favor of political connivance.

★ Texas Medical Association

Room Accommodations For Public Relations Conference

Those desiring room accommodations for the sixth annual Public Relations Conference of the Texas Medical Association on September 17, 1960, at the Association Headquarter's building in Austin may write directly to the following Austin hotels and motels:

The Stephen F. Austin Hotel, 701 Congress Avenue.
The Commodore Perry Hotel, 800 Brazos Street.
The Driskill Hotel, 117 East 7th Street.
Terrace Motor Hotel, 1201 South Congress Avenue.
Holiday Inn Motor Hotel, 6901 Interregional Highway.
Villa Capri Motor Hotel, 2360 Interregional Highway.
Ramada Inn Roadside Motor Hotel, 5650 Interregional Highway.

Saturday evening, following the conference, the University of Texas will play the University of Nebraska in football. Those desiring tickets for the football game may send their checks to the Executive Secretary of TMA, C. Lincoln Williston, 1801 North Lamar, Austin; tickets are $4 each. The Charles O. Finley Company will furnish transportation from the Driskill Hotel, where the Hospitality Hour will be held, to Memorial Stadium for the football game.

Public Relations Conference

Texas Medical Association, Headquarters Building, Austin
Saturday, September 17, 1960

Morning Program, 10:10 a.m.

Call to Order.—DR. RUSSELL L. DETER, El Paso, Vice-President, Texas Medical Association.

Keynote for Conference.—DR. MAY OWEN, Fort Worth, President, Texas Medical Association.

Public Relations Makes the Difference.—REV. CHARLES WELLBORN, Waco, Pastor, Seventh and James Baptist Church.

General Practitioner of the Year Presentation.—Introduction of DR. ELBERT D. RICE, Tyler, by DR. R. HARVEY BELL, Palestine.

Understanding Public Relations.—KENNETH W. HAAGENSEN, Milwaukee, Wisconsin, Director, Public Relations, Allis-Chalmers Manufacturing Company.

The Political Challenge to Medicine.—CLAUDE ROBINSON, Ph.D., Princeton, New Jersey, Founder and Chairman of the Executive Committee, Opinion Research Corporation.

Luncheon, 12:30 p.m.
Afternoon Program, 2:00 p.m.

Today's Youth and Medical Careers.—DR. WALTER S. WIGGINS, Chicago, Secretary, Council on Medical Education and Hospitals, American Medical Association.

Panel Discussion: What's New In County Medical Society PR.—DR. FOY MOODY, Corpus Christi, Member, Council on Public Relations and Public Service, Texas Medical Association.

Physician-Minister Liaison.—DR. TRAVIS SMITH, Abilene, Councilor, District 13.

Medical Student Scholarships.—DR. JACK F. MCKEMIE, Corpus Christi, Chairman, Public Relations Committee, Nueces County Medical Society.

Communicating With Our Publics.—DR. W. M. SHERRILL, Houston, Chairman, Committee on Medical Jurisprudence and Public Relations, Harris County Medical Society.

Immunization Programs.—DR. H. L. STEINBACH, Brenham, Chairman, Committee on Public Relations, Washington-Burleson Counties Medical Society.

Medical Society Newspaper Advertising.—DR. DAVID H. ALLEN, Wichita Falls, Chairman, Committee on Public Relations, Wichita County Medical Society.

How Much Socialism in Tomorrow's Capitalism.—ED WIMMER, Cincinnati, Ohio, Vice-President, National Federation of Independent Business.

Evening Program, 5:30 p.m.

Hospitality Hour.—Courtesy of the Charles O. Finley Company at the Crystal Ballroom, Driskill Hotel, followed by the Texas vs. Nebraska football game at Memorial Stadium, 8 p.m. Tickets for football game are available at $4 each from office of Mr. C. Lincoln Williston, 1801 North Lamar, Austin.

MR. HAAGENSEN

MR. WIMMER

DR. WIGGINS

Orientation Program

Texas Medical Association, Headquarters Building, Austin
Saturday, September 17, 1960

Morning Session, 9:00 a.m.

Welcome: Objectives of the Orientation Program.—DR. WALTER WALTHALL, San Antonio, Vice-Chairman, Board of Councilors.

The Texas Medical Association; An Accounting of Stewardship; What Happens to Your $45 Dues?—DR. ROBERT W. KIMBRO, Cleburne, Chairman, Board of Trustees.

Public Relations and Socio-Economic Considerations in the Practice of Medicine.—C. LINCOLN WILLISTON, Austin, Executive Secretary.

Our Civic and Community Responsibilities.—DR. MAY OWEN, Fort Worth, President.

PR Makes the Difference.—REV. CHARLES WELLBORN, Waco, Pastor, Seventh and James Baptist Church.

General Practitioner of the Year Presentation.—Introduction of DR. ELBERT D. RICE, Tyler, by DR. R. HARVEY BELL, Palestine, Councilor, District 11.

Understanding Public Relations.—KENNETH W. HAAGENSEN, Milwaukee, Wis., Director of Public Relations, Allis-Chalmers Manufacturing Company.

The Political Challenge to Medicine.—CLAUDE ROBINSON, Ph.D., Princeton, New Jersey, Founder and Chairman of the Executive Committee, Opinion Research Corporation.

Luncheon, 12:05 p.m.

Afternoon Program, 1:00 p.m.

Medical Ethics Considerations in the Practice of Medicine.—DR. C. E. OSWALT, Fort Stockton, Chairman, Board of Councilors.

Medical Etiquette; Obligations of the Physician to Colleagues and to the Profession.—DR. R. MAYO TENERY, Waxahachie, Councilor, District 14.

Today's Youth and Medical Careers.—DR. WALTER S. WIGGINS, Chicago, Secretary, Council on Medical Education and Hospitals, American Medical Association.

Serving the Doctors of Texas.—DONALD M. ANDERSON, Austin, Assistant Executive Secretary.

Workmen's Compensation Laws; Charges, Obligations and the Law.—SMITH PETTIGREW, Dallas, Medical Coordinator, Texas Employers' Insurance Association.

Legal Aspects of Medical Practice; Malpractice—How to Avoid It.—PHILIP R. OVERTON, Austin, General Counsel.

How Much Socialism in Tomorrow's Capitalism.—ED WIMMER, Cincinnati, Ohio, Vice-President, National Federation of Independent Business.

Evening Program, 5:15 p.m.

Hospitality Hour.—Driskill Hotel, compliments of the Charles O. Finley Company, followed by the Texas versus Nebraska football game.

The Orientation Program is for provisional members of the Texas Medical Association, who may attend the program any time during a 2 year period. The next programs will be presented in January in Austin and in April in Galveston during the annual session.

DR. ROBINSON

REV. WELLBORN

★ County Societies

County Medical Society Briefs

The *Brewster-Jeff Davis-Pecos-Presidio-Terrell Counties Society* met July 12 at Fort Stockton to hear a presentation by Dr. Harry Demarest, obstetrician and gynecologist from El Paso entitled, "Obstetrical Emergencies."

At the May 10 meeting of the *Nueces County Society,* Dr. Raymond L. Gregory, professor of medicine, University of Texas Medical Branch, Galveston, spoke on "Diagnosis and Treatment of Thyroid Crises."

San Patricio-Aransas-Refugio Counties Society heard a program on "Abdominal Surgery" at its annual meeting June 1 in Sinton. Dr. Richard H. Heard and Dr. Emil Zarsky of Refugio were hosts for the meeting.

The *Brooks-Duval-Jim Wells Counties Society* agreed at its May 3 meeting to distribute a letter to all new families moving in the area explaining the counties local medical facilities and policies. A case report on placenta accreta was presented.

The *Webb-Zapata-Jim Hogg Counties Society* has voted its full cooperation in an area study of care of the aged. Working through a voluntary committee appointed by the county judge, the physicians plan to aid in a survey of facilities and needs for local and state planning.

The *Harris County Society* met May 25 to hear a symposium on the "Treatment of Burns." Participants included Col. Edward Vogel, director of the Surgery Research Center, San Antonio; Dr. T. G. Blocker, professor of surgery at the University of Texas Medical Branch; Dr. S. Baron Hardy, professor of surgery at the University of Texas Medical Branch, Galveston; and Dr. S. R. Lewis, dean of the Postgraduate Medical School at the medical branch.

Dr. Daniel E. Jenkins, professor of internal medicine at Baylor University College of Medicine, was guest speaker at the June 24 meeting of the *Harris County Society.* He spoke on "Widespread Infections Simulating Tuberculosis."

★ District Societies

Four Districts Convene Jointly at Corpus Christi

Districts 5, 6, 7, and 8 met jointly on July 8 and 9 in Corpus Christi, with headquarters at the Robert Driscoll Hotel.

Dr. May Owen, President of Texas Medical Association, addressed the opening session on July 8. Guest speaker for the luncheon on the first day was Allan B. Kline of Western Springs, Ill.

Panel discussion topics included, "Hypothermia—Clinical and Experimental," "Repeated Plasmapheresis in the Same Person—A Rationale for Modern Bloodletting," "Atrial Septal Defects," "Observations of Some of the Problems of Coronary Artery Disease," "Hypertension: Some of the Problems in Diagnosis and Treatment," and "Airborne Infections and Means of Control."

Panel participants included Dr. William W. Bondurant, San Antonio; Dr. Robert O. Brandenburg, assistant professor of medicine at the Mayo Foundation, Rochester, Minn.; Dr. Edward W. Dennis, Houston; Dr. James G. Gabbard, Corpus Christi; Dr. Albert W. Hartman, San Antonio; Dr. F. John Lewis, professor of surgery at Northwestern University Medical School, Evanston; Dr. Joseph Stokes, Jr., professor of pediatrics at the University of Pennsylvania School of Medicine, Philadelphia; Dr. J. A. Welty, Harlingen; and Dr. Norman Woody, assistant professor of pediatrics, Tulane University School of Medicine, New Orleans.

Moderators were Dr. R. Gayle Spann, Dr. J. M. Sloan, and Dr. Kleberg Eckhardt, all of Corpus Christi.

Featured also at the meeting were a golf tournament, fishing, sightseeing, and medical exhibits.

Officers elected for Districts 5 and 6 Medical Societies are Dr. Sloan, Corpus Christi, president-elect; Dr. A. Fletcher Clark, Jr., San Antonio, vice-president; and Dr. John Ethridge, Corpus Christi, secretary-treasurer. Dr. Thelma Frank assumed duties of president.

Officers of the Eight District named during the Corpus Christi meeting are Dr. M. Warren Hardwick, Angleton, president; Dr. Stanley E. Thompson, Richmond, vice-president; and Dr. James L. Coleman, Jr., Victoria, secretary.

The 1961 society will meet July 7-8 in Corpus Christi. Physicians in the Seventh and Eighth District Societies will be invited to participate.

★ Woman's Auxiliary

Woman's Auxiliary Sets School of Instruction

The Woman's Auxiliary to the Texas Medical Association will hold its Executive Board meeting on September 15 and its School of Instruction on the following day at the Association's headquarters building in Austin. Theme for this year's Auxiliary meeting is "Alertness and Action for Achievement."

Registration will begin at 1 p.m. on September 15, and coffee will be served until the board meeting convenes at 2 p.m. Mrs. Ramsay H. Moore, Dallas, President, will preside. Highlights will include a report of the American Medical Association Auxiliary meeting in Miami Beach last June by Mrs. William C. Barksdale of Borger, President-Elect of the State Auxiliary, and announcements of business and plans for the year by Auxiliary officers and chairmen. In the evening, a "get acquainted hour" will be given by Mrs. Moore before a dinner at the Driskill Hotel.

The next morning registration will resume and coffee will be served from 8:30 a.m. until the School of Instruction begins at 9:30 a.m. Round table discussions will be held and evaluated. Dr. May Owen, Fort Worth, President, Texas Medical Association, will speak. A luncheon in the headquarters building at 12:30 p.m., will be followed by a brief meeting. Mrs. James A. Hallmark, Fort Worth, is chairman of the conference and Mrs. William F. McLean, Austin, co-chairman. Mrs. R. T. Travis, Jacksonville, is state program chairman.

Auxiliary members are invited to attend the Public Relations Conference and Orientation Program for physicians on September 17.

PROFILE IN LEADERSHIP

From Ozark Farm to Texas Medicine: Success Story of Dr. B. E. Pickett, Sr.

During the last two decates of the 1800's, an Ozark Mountain boy, born in a log cabin, had to interrupt his education to help support his family. Oldest of a number of youngsters and son of a Confederate veteran whose health was permanently impaired by 4 years in the Army, the boy hired out at farming jobs, splitting rails, hewing cross ties, hauling logs to a saw mill. At 21 he had not been able to attend school enough to complete the eighth grade.

But Britton Elbridge Pickett knew that education was the only road to his life's dream: becoming a doctor.

As soon as younger children in the family were able to assume their part of the family responsibilities, he returned to, and was graduated from, high school, taught in the public schools, took medical courses as rapidly as he could afford to, and worked at a variety of odd jobs in between.

In 1900 he entered medical school in Louisville, Ky. Licensed to practice at the conclusion of his junior year, he returned to Arkansas to do so, going back 5 years later to complete his senior work and graduate from Louisville and Hospital Medical College in 1908. In later years, he took many postgraduate courses, practiced in Big Wells for 20 years, and finally settled in Carrizo Springs.

By 1938, Dr. Pickett—far from the Ozark Mountain cabin in many ways—was listed in "Who's Who Among Physicians and Surgeons" and later in "Who's Who in America." He was elected eighty-second president of the Texas Medical Association in 1947. And he has been for years chairman of the important Council on Constitution and By-Laws of the American Medical Association.

The subject of this success story, now 84, is still busy with his general practice in Carrizo Springs. He is a gentle man of deeply religious nature whose trademark has become the flower which he almost always wears on his lapel. When he has time for a hobby, it is the improvement of a pecan grove he owns.

Members of his family are his wife, a registered pharmacist and medical technologist; a sister, Miss Daisy Pickett, who makes her home with them; a son, Dr. B. E. Pickett, Jr., who is serving an internship in physical medicine and rehabilitation at the Veterans Administration Hospital, Hines, Ill.; and a grandson, Jack Pickett, who was graduated this year from San Marcos Baptist Academy.

Dr. Pickett, as president of the Texas Medical Association, traveled many miles throughout Texas and the nation. He emphasized the absolute necessity of cooperation from every member of the Association official family, insisting that those who did not wish to serve should not accept appointments which would deter the activity of others. During his administration, plans were laid for the presentation of the basic science bill through the Committee on Legislation; activities of the Committee on Public Relations were stimulated; and the Section on General Practice, which Dr. Pickett had advocated for some years, held its first program at the annual session over which he presided.

Just as Dr. Pickett was instrumental in organization of the Section on General Practice for the Texas group, so he was also a member of a three-man executive committee charged with setting up the American Medical Association Section on General Practice for the first time in San Francisco at a 1946 annual session.

His honors have been many. He was Dimmit County health officer for 18 years, and a member of the Texas State Board of Health. He has been president of the Texas Public Health Association, the Southwest Texas District Medical Society, the International Postgraduate Medical Assembly of Southwest Texas. He is a charter member of the American Geriatric Society and a member of the

DR. B. E. PICKETT, SR.

World Medical Association United States Committee. His LaSalle-Frio-Dimmit Counties Medical Society has elected him delegate to the Texas Medical Association House of Delegates year after year since 1915. He was a member and chairman of the Texas delegation to the American Medical Association for a number of years.

At the June, 1960, meeting of the American Medical Association when Dr. Pickett resigned as chairman of the Council and made his last report to the House of Delegates, members from every state in the union gave him a four minute standing ovation.

When he concluded the report he was presented a sterling platter, engraved: "Britton E. Pickett, Council on Constitution and By-Laws, American Medical Association,

1948-1960. 'Behold how good and how pleasant it is for brethren to dwell together in unity.—Psalms 133:1.' "

Thus was ended a service which had begun 31 years before when Dr. Pickett started attending the House of Delegates, sometimes as an alternate delegate. In 1942, he became a regular delegate and did not miss one meeting of the House during his tenure. In 1946, at the San Francisco meeting of AMA he was appointed as a committee of one to revise and rewrite the Constitution and By-Laws, serving for 3 years. He then completed 2 full terms of 5 years each on the Council on Constitution and By-Laws.

Asked to name the medical achievement of which he is proudest, Dr. Pickett selects the Council chairmanship. As head of this council, he guided the then-controversial revised Principles of Medical Ethics to unanimous acceptance by the American Medical Association House of Delegates, a difficult 3-year battle.

"But," admits Dr. Pickett, "the honor I cherish most of my entire life is a bronze plaque given me by the Men's Bible Class of the Carrizo Springs First Baptist Church. It is a token of appreciation for 30 years' service as teacher of the class.

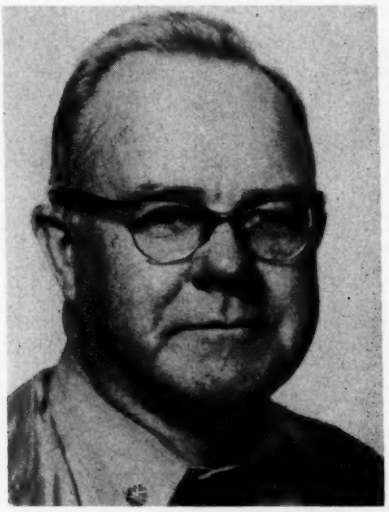
"I treasure this for the reason that other honors bestowed on me or services rendered to humanity by me will pass and be forgotten—but this particular service will, I hope, have its reward in Eternity . . ."

Another profile in leadership: Dr. B. E. Pickett Sr., Arkansas farm boy turned distinguished Texas physician.

DR. W. V. WALLACE

Dr. William Vincent Wallace, Port Arthur, died May 12, 1960. He had recently retired as chief of the United States Public Health Service Outpatient Clinic in Port Arthur, to begin his own practice.

The general practitioner was born February 6, 1896, at Rochester, New York, the son of Dr. William Thomas Wallace and Harriet Mabel (Squier) Wallace. He received his preliminary education in the Rochester schools, taking his bachelor of science degree from the University of Rochester on June 16, 1920. He was graduated from the University of Michigan Medical School, Ann Arbor, Mich., on June 20, 1927, served his internship at the Genesee Hospital, Rochester, and his residency at St. Luke's Hospital, Utica, New York.



DR. W. V. WALLACE

Dr. Wallace began his medical practice in Utica, New York, in 1929, serving there until 1943 when he entered the United States Naval Reserve Medical Corps. In 1946 he joined the United States Public Health Service at Port Arthur.

Earlier, in 1918, Dr. Wallace served briefly as a second lieutenant in the United States Army.

A member of the American Medical Association and the Texas Medical Association, Dr. Wallace also belonged to the Kiwanis Club, having served as president of the Downtown Kiwanis Club of Port Arthur; was a thirty-second degree Mason, member of the El Mina Temple of the Shrine, the Port Arthur Shrine Club, the American Legion, the Veterans of Foreign Wars, and the Propeller Club. His church affiliation was Episcopal.

Dr. Wallace' hobby was philately, the collecting and study of postage stamps.

Survivors include his wife, the former Mrs. Dorotha Gifford Young of Port Arthur, whom he married on February 2, 1951. His first wife died May 8, 1950. Surviving also are two daughters, Mrs. Patricia Joan Fowle, Nederland; Mrs. Elizabeth Jean Hill; a son, William John Wallace, Port Arthur, and a brother, Dr. Herbert Northrup Wallace, Poland, New York.

DR. R. S. ROSENTHAL

Dr. Raoul Simon Rosenthal, Dallas, died May 25, 1960, in his office of a heart attack.

Dr. Rosenthal was born in New Orleans on September 10, 1909, and received his preliminary education in Dallas. He attended Louisiana State University in Baton Rouge from 1928 until 1930 and obtained his medical degree in 1934 from Baylor University College of Medicine when the college was located in Dallas. He served his internship

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An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

DR. R. S. ROSENTHAL

in Parkland Hospital, Dallas, and his residency at Parkland and at Bellevue Hospital, New York. In addition, he undertook 6 months of postgraduate work at Cook County Postgraduate School, Chicago.

Specializing in obstetrics and gynecology, Dr. Rosenthal was a fellow of the International College of Surgeons, and of the American College of Obstetricians and Gynecologists. A member of the American Medical Association and the Texas Medical Association, Dr. Rosenthal was affiliated through the Dallas County Medical Society.

He belonged to Temple Emanu-El, Tannehill Masonic Lodge, the Dallas Consistory of Scottish Rite, Hella Temple, and the Columbia Club.

He spent 14 months as a medical officer with the United States Navy, attached to the Marine Corps. He was in action in the Pacific during World War II and was discharged from the service as a lieutenant commander.

He was married June 8, 1941, to Miss Beryl Norman of Patterson, La., who survives. Also surviving are his son, Raoul Simon Rosenthal, and daughter, Gayle Rosenthal; a brother, U. J. Rosenthal; and a sister, Mrs. Oscar Blatt, all of Dallas.

DR. J. M. COLEMAN

Dr. James Meredith Coleman, an Austin pediatrician, died June 2, 1960, in St. Louis of a heart attack.

Dr. Coleman, his wife, and daughter were in St. Louis on a combination business and vacation trip. He was attending a postgraduate symposium on allergy sponsored by the Hansel Foundation.

Born November 30, 1906, in Brinkley, Ark., Dr. Coleman received his early education at Fort Smith, Ark., and attended Ouachita College at Arkadelphia, Ark., from 1924 until 1926. He received his medical degree from Baylor University College of Medicine in 1930, when the school was located in Dallas. Undertaking his internship and residency at St. Louis City Hospital, Dr. Coleman continued his postgraduate work at Harvard University School of Public Health, Boston, 1937-1939. He also studied at Vanderbilt University School of Public Health, the University of Wisconsin, and the University of Chicago.

An author of many medical articles, Dr. Coleman was active in numerous civic and medical affairs. He began his medical practice in 1934 in Plano as a general practitioner, moved to Austin in 1937 where he became director of maternal and child health for the Texas State Department of Health. He later was director of public health, welfare, and hospitals and was resident surgeon with the state health department from 1941 to 1946. He entered private practice in Austin in 1946.

Organizer of Children's Medical Center, Austin, Dr. Coleman had served the Travis County Medical Society from 1954 to 1956 as president and in 1943 as secretary. A member of Texas Medical Association, he was on the Board of Councilors from 1952 until 1954, was secretary of the Section on Public Health in 1941 and chairman of the section in 1943.

DR. J. M. COLEMAN

Also a member of the American Medical Association, Dr. Coleman was a diplomate of the American Board of Pediatrics and a member of the American Academy of Pediatrics. He held membership in Alpha Omega Alpha honorary medical fraternity and Delta Omega, honorary public health fraternity. He was a member of the Board of Health of Austin, which he had served as chairman, a member of the advisory committee to the Children's Bureau, a member of the President's Committee on Nutrition in 1941, and he had been chairman of the commission for study of special education for Austin Public Schools. He also belonged to the Texas Pediatric Society and the Austin Pediatric Society.

A Baptist, Dr. Coleman was a member of the Westwood Country Club, the Journal Club, and the Chamber of Commerce.

Flower gardening with an emphasis on cactus and iris, medical history, photography, and painting were his hobbies.

Survivors include his wife, whom he married June 12, 1933, in Houston; a daughter, Miss Evelyn Shannon Coleman of Austin; a son, James Meredith Coleman III, a

Marine Corps pilot; and a sister, Miss Mary Rebecca Coleman of Dallas.

Friends of Dr. Coleman have contributed more than $600 to the James M. Coleman Memorial Fund, a permanent endowment which Dr. Coleman and his wife had initiated in 1959 for use of the Texas Medical Association Memorial Library. Dividends will be used to strengthen the pediatric and medical history collections of the library. As a member of the Committee on Medical History, Dr. Coleman had often contributed to the library section of the *Texas State Journal of Medicine*, and he was one of the most ardent users of the library.

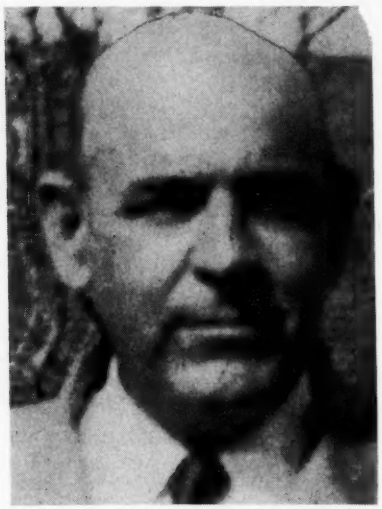
DR. ERNEST W. JONES

Dr. Ernest William Jones, resident physician on the staff of Rusk State Hospital since 1956, died May 10, 1960.

The son of John T. and Molly (Rice) Jones, the physician was born September 11, 1902, in Muldoon.

He attended school in Smithville, received his academic training at the University of Texas, Austin, and his medical degree in 1928 from Baylor University College of Medicine, when the school was located in Dallas. Dr. Jones served his internship in 1928 and 1929 at Hermann Hospital, Houston.

From 1941 until 1946, he served in the United States Army Medical Corps at Camp Hulen near Palacios, at Hines General Hospital, Chicago, and in the Aleutian Islands. He held the rank of major.



DR. ERNEST W. JONES

Dr. Jones had served as president of the Karnes-Wilson Counties Medical Society in 1953, had belonged to Colorado-Fayette Counties Medical Society, and at the time of his death he was a member of the Cherokee County Medical Society. He belonged to the Texas Medical Association and the American Medical Association. He had practiced from 1932 to 1940 at Eagle Lake, and from 1940 to 1956 at Kenedy. At that time he retired from private practice to join the hospital staff at Rusk.

Dr. Jones' hobbies were fishing and hunting. He was a member of the Methodist Church.

On April 29, 1933, Dr. Jones was married to Miss Bessie McLellan, daughter of Dr. and Mrs. R. L. McLellan of Eagle Lake, at Lake Charles, La.

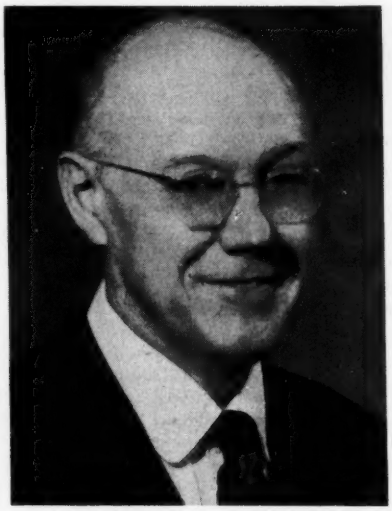
Surviving besides his wife are a son, Robert Davis Jones of Houston; two brothers, T. P. Jones, Smithville; Clyde Jones, Fort Worth; three sisters, Mrs. Beulah Barta, Smithville; Mrs. Joe Bear, Denison; and Mrs. N. H. Downing, Wichita Falls.

DR. F. W. HOWELL

Dr. Floyd Wayne Howell of Temple, died May 25, 1960, at a Temple hospital following a lengthy illness.

Dr. Howell was born February 29, 1904, in Florence. His parents were James De Bose and Annie Mae (Stokes) Howell.

A graduate of Florence High School and Howard Payne College at Brownwood, Dr. Howell received his medical degree from Baylor University College of Medicine in 1930, then located in Dallas.



DR. F. W. HOWELL

He interned at King's Daughters Hospital, Temple, and has been a general practitioner in Temple since 1931. He was on the staff of Scott and White, Santa Fe, and King's Daughters Hospitals.

Dr. Howell was married to Miss Ora Mae Mullen of Florence on February 7, 1926, in Carson City.

He was a member of the American Medical Association, the Texas Medical Association, and the Bell County Medical Society. In addition, he belonged to the American Academy of General Practice and the Texas Academy of General Practice. He also was a member of the First Presbyterian Church of Temple, where he served as an elder for many years.

Survivors include his wife; three sons, James William Howell, Shelley Mullen Howell, and Jon Allan Howell, all of Temple; his father, J. D. Howell of Florence; and a sister, Mrs. Jewell Rice of Austin.